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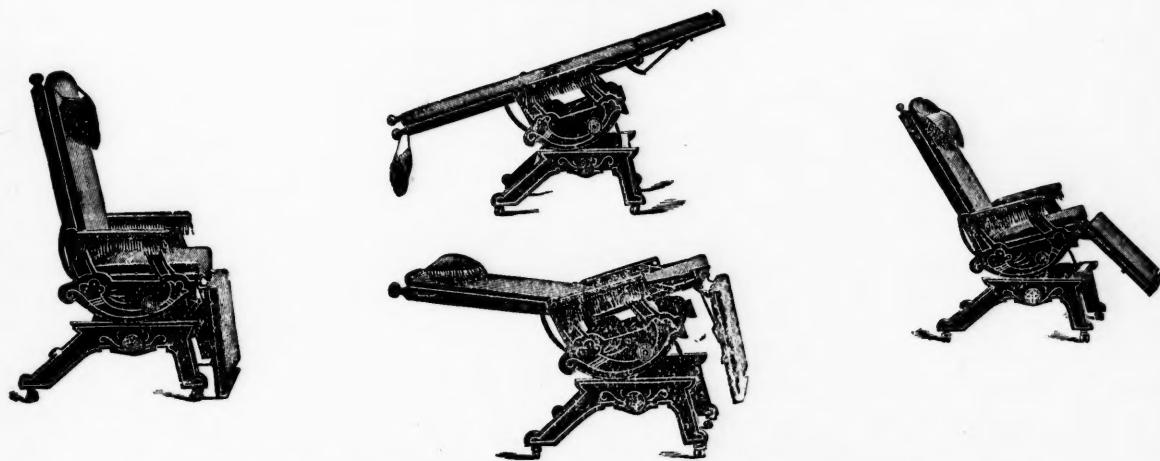
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Prof. Wm. A. Hammond, M.D., in the course of some interesting remarks before the New York Neurological Society, on Tuesday evening, November 2, called attention to the impurities existing in most of the preparations of wine of coca, which vitiated their value, and he then said:

"Most of the wines of coca contain tannin and extractives, which render the taste of the article astringent, most disagreeable, and even nauseating, especially in cases where the stomach is weak. The difficulty arises from the fact that these wines of coca are made from the leaves, or even from the leavings after the cocaine has been extracted. The active alkaloid, which is the essential element, is therefore wholly lacking in some of these preparations, and this renders them practically worthless."

"I therefore asked a well-known gentleman of this city if he could not prepare a wine of coca which should consist of a good wine and the pure alkaloid. He has succeeded in making such a preparation. It seems almost impossible that there could be any such a substance, for its effects are remarkable."

"A wineglassful of this tonic, taken when one is exhausted and worn out, acts as a most excellent restorative; it gives a feeling of rest and relief, and there is no reaction and no subsequent depression. A general feeling of pleasantness is the result. I have discarded other wines of coca and use this alone. *It is the Health Restorative Co.'s preparation.* (Italics ours.)

"I have found it particularly valuable in cases of dyspepsia and weak stomach. The cocaine appears to have the power to reduce the irritation of the stomach and make it receptive of food. In extreme cases, where the stomach refuses to take anything, a teaspoonful of the wine may be tried first; the stomach will probably reject it. Another teaspoonful may be given, say fifteen minutes later, and this will possibly share the same fate; but by this time the cocaine in the wine will have so reduced the irritation of the stomach that the third teaspoonful will be retained, or at least the fourth or fifth, and the stomach thus conquered will be in a condition to retain food, which should be given without the wine."

"This wine of coca may be taken by the wineglassful, the same as an ordinary wine; there is no disagreeable taste; in fact, it tastes like a good Burgundy or Port wine. Taken three times a day before meals or whenever needed, it has a remarkably tonic effect, and there is no reaction. The article produces excellent results in cases of depression of spirits; in hysteria, headache, and in nervous troubles generally it works admirably. It is a simple remedy, yet efficacious and remarkable in its results."

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A complete Antipyretic, a Restorative of the highest order, and an Anode of great Curative Power

R.—Each pill contains the one-sixth of a grain of the Hydrochlorate of Cocaine, two grains of the Sulphate of Quinine, and two grains of Acetanilide.

In the dose of one or two pills, three times a day, "Febricide" will be found to be possessed of great curative power in Malarial Affections of any kind, and in all inflammatory diseases of which Fever is an accompaniment. For Neuralgia, Muscular Pains, and Sick Headache, it appears to be almost a specific. Reports received from Physicians of eminence warrant us in recommending "Febricide" in the highest terms to the Medical Faculty.

N. B.—The pills being made *without excipient*, and with only coating sufficient to cover the taste, their solubility is almost instantaneous, and consequently of great advantage where prompt medication is required.

Dr. R. C. McCurdy, of Livermore, Pa.: Have used FEBRICIDE in two cases with *grand results*. In one case of sick headache it acted immediately.

Dr. A. J. Rogers, Juniata, Neb., writes: Your sample of FEBRICIDE had not been in my hands an hour when I was called to see an old lady suffering severely with *Rheumatism* and *Hyperesthesia* which was very general, and also with *Asthma*, of which she had suffered for many years. I gave her a pill three times a day until she had taken eighteen. She began to get relief after the fourth pill and continued to improve. By the time she had taken twelve pills, *Rheumatism* and *Acute Sensitiveness* were no more, and she has not felt anything of them since.

Dr. J. A. Brackett, of Pembroke, Va.: "I have used Febricide in case of childbed fever with remarkable effect, temperature 103°. I had tried other usual remedies without much change; soon after using Febricide the change was like magic."

Dr. C. E. Dupont, of Grahamville, S. C.: "Febricide has proved of great benefit to the patient I tried it on. It was a case of Malarial Toxemia in an old lady; the attacks had become very irregular and lately had been attended with intercostal neuralgia, which alarmed her exceedingly. The pills acted well and quickly, as heretofore it usually took me ten days, at least, to relieve her of an attack, but this time she was up on the fourth day and wanting to go on a visit."

P. M. Senderling, A.M., M.D., of Jersey City, N. J. writes: July 13 I was called upon to visit a lad aged 18 years, who had been suffering for over two weeks with, as alleged, "Inflammatory Rheumatism," and had been attended by another doctor and discharged as convalescent a week prior to my first visit. I found him in this condition: pulse 110; temperature (under tongue) 103 3/5; the right knee-joint greatly swollen and intensely painful, a troublesome diarrhea also present. Careful inquiry and examination demonstrated to my mind that the difficulty or "Materies Morbi" was clearly traceable to malarial influence. I at once placed him under the treatment which for years I had found most efficient, but up to the 16th I had utterly failed to reduce either his temperature or frequency of pulse. On my morning visit of 16th I found his condition thus: temperature (under tongue) 104 2/5; pulse 116 and his general condition indicative of great suffering. I at once suspended all other treatment and gave him one pill "Febricide" every three hours. At 8 P.M., 16th inst. I found my patient much better, his temperature had fallen to 102; pulse 96; and his general appearance indicating decided improvement in every particular. On 17th his temperature had fallen to 101 1/5; pulse 90; 18th 100 1/5; pulse 90, and with great improvement in condition of knee-joint, the swelling, abnormal heat and sensitiveness were entirely gone. I am so confident this case will speedily and perfectly convalesce, that I do not deem it necessary to delay communicating the result of my first trial of the "Febricide." I will say that in this case antifebrin and antipyrin were successively tried in full doses, and to meet the synovitis, full doses of quinine and salicylate of soda were also used; the local treatment being alkaline lotions which I did not discontinue.

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I trust the profession will give them a trial, feeling confident that they will be well pleased with the results obtained. Yours respectfully,

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ATCHISON, KAS., June 29, 1889.

Hon. Albert H. Horton, President of the GUARANTY INVESTMENT COMPANY,

DEAR SIR: As a Committee of Investors appointed to make the annual examination for 1889 of the Company's Loans and methods of business, we respectfully submit the following report:

We take pleasure at the outset in commending the policy of the Company in making an investigation of this kind, and consider it a wise one for the Eastern Investor, as it enables him to obtain disinterested information in regard to a class of Securities which is continually attracting greater attention in the older States.

In order that it may appear that this information is absolutely unbiased, we would say that no instructions of any kind were given us, except to make the investigation thorough and to report faithfully the results of such examination.

In carrying out our plan of operation, we examined carefully the methods employed at the Atchison Office, in keeping the record of all Loans, and in addition, travelled over two thousand miles in Kansas and Nebraska, examining the lands upon which Loans have been made. We drove in carriages about seven hundred miles, and visited over fifty Counties in the two States.

We were able to examine over 100 different Loans, and in many instances talked with the Mortgagors about the prospects for crops, and their ability to meet payments of interest and principal.

These Mortgages range from \$200.00 to \$3000.00, and we take pleasure in stating that we did not examine a single one which in our opinion was unsafe. Some of the Loans were held by different members of your Committee, and we would not be likely to report them as safe, unless they were so in reality.

The prospects for crops were exceedingly good throughout Kansas and Nebraska, and in many sections a very heavy yield of wheat and oats had been already harvested.

In conclusion we would say that we were highly pleased with the methods employed by the Company in making and taking care of its Mortgages, and shall be inclined to purchase more of them and to recommend them to others.

Yours respectfully,

IRVING H. TIFT,

FRANCIS W. BOYER,

M. H. OLIN.

A more detailed Report was made by the Committee, and the Company will be pleased to mail it, together with a very interesting pamphlet descriptive of the general development of Kansas and Nebraska.

The Company keeps on hand at all times a large number of loans equally as safe as any examined by the Committee.

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(Please mention The Times and Register.)

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	MILK SUGAR	64 "	and compare it with every
	FAT	10 "	other food used in artificial
	MINERAL MATTER	3 "	feeding of Infants.
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	MOISTURE	3 "	

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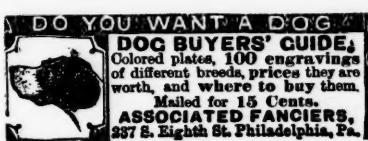
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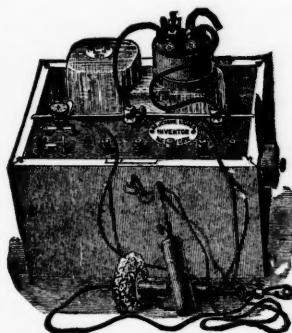
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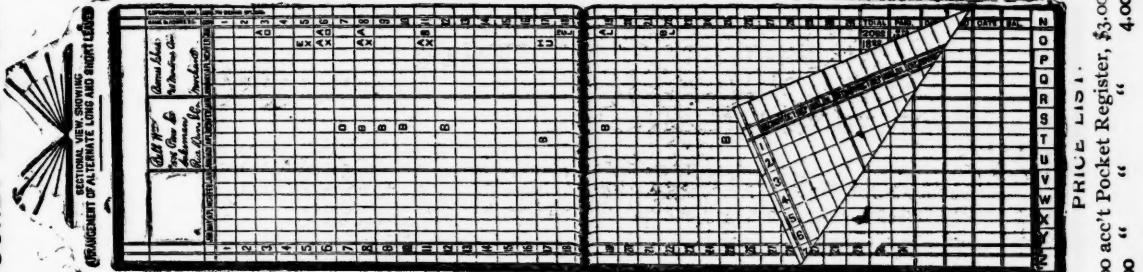
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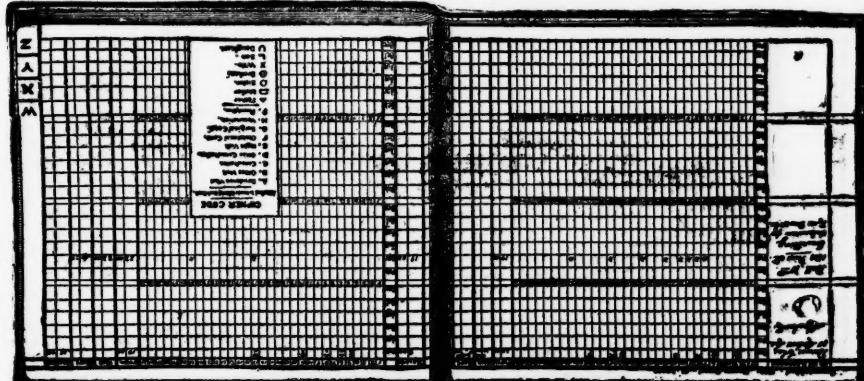
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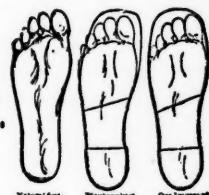
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Clinical Lecture.

AMPUTATION OF THIGH FOR ELEPHANTIASIS ARABUM.

BY JOHN W. CROSKEY, M.D.,
Chief of Clinic, Medico-Chirurgical Hospital.
(Reported by GRIFFITH J. THOMAS.)

GENTLEMEN: In the absence of the surgeon of this clinic, Prof. Goodman, I have the honor of appearing before you to-day with a case no less interesting than it is rare in this country and latitude. The patient came under my observation about one month ago. The leg presented the enormous size that you now witness, and bears, as you see, a marked resemblance to the leg of an elephant. It measures seventeen inches around the calf. The integument is white and lustrous, and upon closer inspection the epidermis is seen to be desquamating, a condition produced by lack of nutrition, consequent to the hypertrophy of the skin and subcutaneous tissue—the structures pathologically involved in this affection in connection with the lymphatics. To affections of this kind the name elephantiasis is given, a name significant of the enormous hypertrophy of the affected part. To designate the different varieties of the disease, epithets are used which are chiefly the names of the different countries in which the disease occurs in its various forms. Thus, the case before us corresponds more closely with the kind known as elephantiasis arabum, which prevails chiefly among

the Arabians, and in whose country it is believed to be hereditary and contagious. It is, as I have already remarked, a chronic hypertrophy of the skin and subcutaneous tissue, occasioning enormous enlargement and deformity. It is supposed to be the result of repeated attacks of inflammation of the lymphatics and skin. The term elephantiasis is applicable to any enormous hypertrophy of the skin from whatever cause it may arise. It is not common in this country, but is endemic in tropical countries. It occurs more frequently in males than in females, and affects those who are poor and ill fed rather than those who are well fed and obey the laws of hygiene.

When the disease first appears there are severe constitutional symptoms, resembling those of intermittent fever. Inflammation of the part usually follows the fever, and the skin becomes red, tense, tender, attended by an intense burning sensation and discharge of a serous or chyle-like fluid, and, on the whole, presenting all the characteristics of an attack of erysipelas. These symptoms subside, but the part remains swollen and distorted, although free from pain and heat. The condition of the limb after the first few attacks, is apparently oedematous, pitting upon pressure, but after several attacks the part becomes hard and dense, with an anaesthesia of the skin. In the case before us the inflammatory condition still exists, and that stage has not yet been reached when heat and pain are absent, since the patient cannot endure the pressure of his clothes upon the limb, all that he can bear upon it being a

piece of mosquito bar. The disease is rapidly extending up the limb, and to stay its progress is the object of the operation to be performed before you to-day.

To the naked eye a section through a limb affected with elephantiasis arabum presents an appearance of layers, enormously thickened, of the corium, subcutaneous tissue, fasciae and periosteum. The muscles, however, become atrophied from long continued pressure and want of use. As to the treatment of this disease, it can be said that medicines have little or no effect upon it. Martin's elastic bandage has been used successfully in the prevention of the hypertrophy. Electricity has also been tried with some success. Compression of the main artery by digital pressure, ligation of the main artery, and section of the nerve, are other methods that have been tried. The latter was done in the case of a negro, aged fifty, at the Pennsylvania Hospital, in this city. He had elephantiasis of the right leg. Dr. Morton excised a portion of the right sciatic nerve. The operation was followed by a rapid diminution in the size of the leg, the calf being reduced from twenty-three inches to seven inches in seven weeks. This patient, some time after the operation, was attacked by pleuro-pneumonia, and later by a deep-seated suppuration in the opposite limb. The pulmonary trouble developed into a catarrhal phthisis, from which he died five months after the section of the nerve. Amputation is another mode of treatment by operative means, and such an eminent authority as Agnew tells us that only excision and amputation appear entitled to confidence.

Our patient presents a very interesting history, which I will read: Capt. Chas. D. Foy, born at Downingtown, Pa., aged sixty-three years. Served in the Mexican war, during which he was wounded in the knee. Later, served in the war of the Rebellion. While quartermaster at Falmouth, Va., was accidentally thrown from a train, sustaining a fracture of the os calcis of the left foot, on account of which he was laid up in a hospital for three months. Upon being discharged from the hospital he returned to the front, but was unable to endure long marches, as his foot thereby became weak and painful. Upon expiration of the period of his enlistment he came to Philadelphia, and placed himself under the treatment of an electrician, who did him so much good that he returned to the front once more. He was not actively engaged, however, during his second enlistment, but his foot began to grow worse, giving him much pain. Returning to the city in 1865, he again tried electrical treatment, but experienced no relief. About a year later his ankle began to swell, attended with an increase of pain. He was engaged for many years as a railroad conductor, but was obliged to give it up on account of his leg, which continued to enlarge from the time the swelling first began in the ankle. As the leg grew in size, it also grew more painful. In 1885 the leg began to grow more rapidly. It soon became so cumbersome that patient was unable to go around. The pain also became so intense that the pressure of clothes upon limb could not be endured. In 1886, suppuration set in, and pus was freely dis-

charged from two openings beneath the internal malleolus. These running sores continued for six weeks, when they dried up. In 1887, upon recommendation of the Surgeon-General, he consulted Prof. Goodman, who advised him to have the limb amputated, when it could have been saved about six inches below the knee. Vainly hoping for relief, he deferred having it done. But within the last two years the limb continued to grow worse, increasing in size, the swelling gradually ascending. It would frequently break down into suppurating sores, which would discharge a while and then dry up. The skin became very much thickened, and covered with small vesicles containing a serous fluid. He has been unable to go about the house, being obliged to sit in the one place continuously. In this condition I found him, and at his request he was brought to this Hospital to have done that which it would have been wise to do two years ago. He has been in the Hospital about a week, during which time especial attention has been paid to getting him in that constitutional condition best calculated to endure to-day's ordeal.

The patient being now well under the influence of ether, the leg is held up to allow it to be drained of its blood, as the patient needs all the blood we can possibly preserve him. Ordinarily, we would apply a Martin's bandage to the whole limb to a point a little above the line of amputation, but owing to the condition of the limb, the bandage is applied just from the knee up. The Martin's bandage drains the blood more thoroughly from the part to be removed than it can possibly be done by manual pressure. To control the hemorrhage incident to the operation, we apply a tourniquet, with the pad pressing upon the femoral artery. We will make antero-posterior flaps of the integument and fasciae, and circular of the muscle, in the lower third of the thigh. In this wise we secure two things that are desirable, viz.: cicatrix, or line of union, behind the bone, and the section of nerves and vessels at right angles to their main axis. We will ligate with chromatized catgut, the vessels which we find are difficult to ligate in this case, being in an atheromatous condition. The hemorrhage being stopped, we apply, before closing the wound, boroglyceride to the raw surfaces to secure asepsis. The flaps are sutured together with softer catgut, which we will also use for drainage. The wound will now be dressed antiseptically with iodoform and bichloride gauze. The dressing is not to be removed until complete union has taken place, unless suppuration sets in, which, should it occur, will be indicated by a decided and continued elevation of temperature.

The following is the daily record of the case after the operation, from which it will be seen that the dressing was retained twelve days before being removed:

August 29.—Evening temperature, 99° F.

August 30.—Morning temperature, 98.8° F.; evening temperature, 99.4° F.; one movement of bowels by injection. Was given the following: Hydrarg. chlor. mitis, gr. j; sodii bicarbonatis, grs. xi; sacci albi, q. s. m. ft., chart No. VI. One every hour.

August 31.—Morning temperature, 99° F.; evening temperature, 102.4° F. Continued at this point for

about an hour, then fell to 100.6° F. One movement of bowels by injection.

September 1.—Morning temperature, normal; evening temperature, 99.4° F.

September 2.—Morning temperature, normal; evening temperature, 99.8° F. Was given elix. quininæ, ferri et strychninæ, teaspoonful thrice daily.

September 3.—Morning temperature, normal; evening temperature, 99° F. One movement of bowels.

September 4.—Morning temperature, normal; evening temperature, 99.2° F.

September 5.—Morning temperature, normal; evening temperature, normal. Two movements of bowels.

September 6.—Morning temperature, normal; evening temperature, normal.

September 7.—Morning temperature, normal; evening temperature, 99° F. One movement of bowels.

September 8.—Morning temperature, normal; evening temperature, 99° F.

September 9.—Morning temperature, normal; evening temperature, 99° F. One movement of bowels; some little discharge from dressing; removed; perfect union; no suppurating points; catgut drainage entirely absorbed. Redressed.

September 10.—Morning temperature, normal; evening temperature, 99° F. Two movements of bowels, morning and night; patient sitting up.

September 11.—Morning temperature, normal; evening temperature, 99.4° F. One movement of bowels.

September 12.—Morning temperature, normal; evening temperature, 99.4° F. One movement of bowels.

September 13.—Morning temperature, normal; evening temperature, 99.8 F.

September 14.—Morning temperature, normal. Two movements of bowels. Patient looks and feels well, and is rapidly going on to recovery.

organisms and disease. Bacteria have been found in the products of pericardial inflammation when they were not present in the blood. The most we are warranted in assuming at present, is that microbes in the system may produce some poisonous substance or alteration in the tissues or the blood, so as to result in inflammation of that point in the physical economy, which, for the time, is below the power of successful resistance. The artificial production of such a point previous to the introduction of a microbe simply proves that they will attack such a point, and not that they will actually produce it. The doctrine of *phagocytes* is a tempting one in this connection—that to a destruction of phagocytic cellular action is due the production of a point of deficient resistance. At all events, the necessity for a specific bacillus for the production of pericarditis is not recognized as yet.

In regard to rheumatic pericarditis, we know as much as we do about rheumatism. According to Bamberger, about 30 per cent. of the cases of pericarditis occur in connection with acute articular rheumatism. Clinically, we are not able to tell which cases are liable to this complication, further than that it more often occurs in those where several joints have been successively attacked, and the rheumatic manifestations shifting in character. Da Costa states that endo- and pericarditis generally attend each other, and that pericarditis without endocarditis is more frequently met with than the contrary condition. This statement is misleading; proportionately, it may be true, but actually endocarditis, uncomplicated by any other cardiac lesion, is much more frequently obtained in rheumatism than is a similar condition of the pericardium. Debilitated persons are more likely to have pericarditis complicating rheumatism than robust persons; in the latter the cardiac trouble is generally endocarditis.

Pathologically, the cause rests in an inflammatory nutritive derangement, resulting in proliferation of the pericardium, interstitial exudation, or free exudation, plastic, or serous, depending upon the condition and extent of the inflammatory process. The anatomical changes wrought in the pericardium are important, and have much to do with our prognosis. The small hypertrophies of the connective tissue—subepithelial, as well as the whitish tendinous spots called by Sehnenflecke *maculae albideæ lactæ*, are of no clinical interest. The vascular injection of the tissue, loss of epithelium and of luster, the villous appearance due to proliferation of young connective-tissue cells, the exudation of serum, clear or flaky, or heavily charged with fibrin, which may become fibrillated on the walls of the pericardium—cor *villosum* or *cor hirsutum*, the latter being the condition most frequent in acute articular rheumatism; these appearances are all familiar and need not be dwelt upon. When the plastic exudation has been considerable, thickening of the pericardium may result from connective-tissue organization, incomplete absorption of the inflammatory products; there may be masses of cheesy material covering the thickened fibrous pericardium. This condition will be further considered hereafter. Small amounts of effusion are said to accumulate around the base of the heart, but unless there

Original Articles.

RHEUMATIC PERICARDITIS.

(Read before the Chicago Pathological Society, September 9, 1889.)

BY JOSEPH M. PATTON, M.D.,
CHICAGO, ILL.

IN considering the subject of rheumatic pericarditis, I have endeavored to confine myself as closely as possible to pericardial inflammation of rheumatic origin; but as the distinction is chiefly an etiological one, the symptoms and course being much the same as in pericarditis arising from other causes, you will pardon such general observations as are necessary in the elucidation of the subject.

Etiologically, inflammation of the pericardium stands in much the same position as it did ten years since, the pericardium having generally escaped investigation in the hunt after microbes. Recently this subject has been investigated in a few instances; one observer has succeeded in inducing pericarditis through culture from an inflamed pericardial surface, in a pericardium previously irritated by turpentine; the relation between cause and effect, in this instance, is rather characteristic of some of the theories given in regard to the etiological relations of micro-

should be adhesions limiting the pericardial space, I do not see why this should be. Large amounts of effusion may distend the sac, interfering greatly with cardiac motion, besides softening the cardiac tissue. Myocarditis frequently results from inflammatory extension; ventricular dilatation may result from weakening of muscular tissue.

The subjective symptoms occurring in the course of acute articular rheumatism are not at all characteristic. There is nothing to particularly emphasize the onset. As a rule, there will be no rigor, little or no additional rise in temperature; the pulse may be accelerated or retarded; pain to the left of the epigastrium, and over the cardiac region, palpitation and dyspnoea are the chief signs, yet they may be absent. Again, the symptoms may be marked, with a sense of impending danger. The pain is dull or lancinating in character, and when excessive is due to pleurisy. The palpitation varies in character. In the early stages there may be forcible, irregular, irritable heart's action, which is not due to loss of muscular integrity. This palpitation is at times pronounced, and while it may be a theoretical explanation only to ascribe the cause to irritation of the cardiac ganglia, it is still the most plausible one that can be advanced. The three largest of the minute ganglia, which are found on the nerves in the heart tissues, are the ganglion of Bidder, near the mitral valve; the ganglion of Ludwig, in the inter-articular septum; and the ganglion of Remak at the mouth of the vena cava. According to Kolliker, they are connected only with the sympathetic; according to Beale only with the fibers of the vagus. The afferent branches furnished by the vagus are cervical and thoracic. The first, second, and third cervical nerves anastomose with the carotid plexus of the sympathetic and inferior laryngeal; the thoracic branches with the cardiac filaments of recurrent and branches of great sympathetic. The middle cardiac nerves of Hirschfeld are an indirect communication by way of the recurrent, anastomosing with superior cardiac nerves of vagus and with the sympathetic. The superior, middle, and inferior cardiac nerves of the sympathetic from the superior, middle, and inferior ganglia and first thoracic ganglion anastomose with each other, with laryngeal plexus and the cardiac thoracic branches of vagus. Physiologists have described centripetal branches with the depressor nerve of Cyon, centrifugal branches with the accelerator nerve of Cyon, and accelerator branches from the spinal cord going to loop of Vieussens—a double branch connecting last cervical ganglion with the first thoracic ganglion—which, according to Bezold and Cyon, is the center of accelerator nerves. These various nerves, with their intricate series of plexuses and planes of communication, serve to make any direct theory, as to the exact route of a nervous influence, more or less problematical. It would seem, however, in view of the various symptomatic cardiac disturbances which arise in a reflex manner, as from the stomach, that the irregularity is one which involves the cardiac portions of the sympathetic; and if the cardiac ganglia belong to this system, and they probably do, then irritation of these ganglia may be the cause.

With much effusion the heart's action is wavy and indistinct, conveyed over a considerable area; with muscular degeneration and dilatation there is labored cardiac action, lifting a considerable portion of the cardiac area, with some epigastric motion, the whole being out of proportion to the vascular tension.

Dyspnoea may result from passive congestion of the lung, or from pressure or effusion, and from the latter cause may be very severe, when there is comparatively little disturbance of cardiac action. The patient assumes that position which allows of the freest action of the right lung.

Every case of acute rheumatism should be carefully and frequently examined for pericarditis, as it may come on so quietly as to allow of the accumulation of a large effusion before it is discovered.

Inspection will reveal the character of the cardiac action as given above, or there may be some bulging of the cardiac region with large effusion in young subjects; in older persons ossification of the cartilages may prevent this. Palpation reveals the above conditions, the apex may be in the proper position, or may be displaced, it may be forcibly, or almost imperceptibly, and somewhat lower down as the effusion distends the sac. Bending forward and allowing the heart to gravitate against the chest wall may increase the force of the impulse.

Percussion is negative unless there is effusion; if the effusion is small in quantity, there would be a line of dulness extending from the fourth rib to the apex, obliquely beneath the sternum, and would be very difficult of detection. Some writers claim that small effusions give dulness about the base of the heart, at or above the second rib. This view, I believe, is due to faulty appreciation of the anatomical conditions. In a number of autopsies which I have made, where there were several ounces of fluid in the pericardial space, I had not observed dulness over the base, and in most instances was not able to diagnose the presence of fluid *ante mortem*. Rotch gives dulness to right of sternum in fifth intercostal space as a valuable sign in small effusions; with a healthy heart this may be a useful sign, but with right ventricular hypertrophy it would probably be difficult to determine its value. Large effusions give pyramidal dulness, extending from the second to the sixth, and from the right of the sternum to the left of left mammary line. The dulness may change somewhat with changed position, the lung closing over the heart as it gravitates backward in the recumbent position, and lessening the area of dulness, or the compression of a large effusion may allow of no change; in this instance the heart may gravitate back within the sac, and by forcing the fluid forward distend the sac one-third larger than in the erect posture; extension of dulness to left of apex beat may give good evidence of effusion. Auscultation gives the most distinctive sign when it can be obtained, and it generally is present in rheumatic pericarditis. This is the friction sound. This sound is synchronous with the heart sounds, but is longer, and can be heard after their cessation; it is harsh, grating or creaking in character, and may at times be very difficult of detection. It is heard over the ster-

num from the second to the fourth rib, is increased by bending forward, and diminished in the recumbent position. It may be present during a portion, or the whole, of the disease; also when there is considerable fluid present, it is then heard about the base of the heart. Great distention of the sac by fluid may displace it entirely. The friction sound is to be distinguished from valvular murmurs, pleuritic frictions and cardio-respiratory murmurs. From valvular murmurs differentiation is easy; their character, direction of transmission, and other evidences of organic disease will prevent confusion. From pleuritic friction the cessation of sound with suspension of respiration affords a clear distinction. Here it must be borne in mind that pleuritic friction may be caused by cardiac action, and would then continue during suspension of the respiratory act. The so-called cardio-respiratory murmurs, inspiratory and expiratory, produced in the tongue of lung overlying the heart, and caused by the impulse given the air in the lung by the cardiac systole during expiration, cardio-expiratory, and by the suction action of the vacuum, caused by the systole during inspiration, cardio-inspiratory, can hardly be mistaken for pericardial friction by one accustomed to the sound; still as they occur at the same time they should be remembered. They, of course, cease during cessation of respiration.

The heart sounds may be exaggerated, or when there is much effusion, very distant and indistinct. This faintness of the heart sounds, entirely incompatible with the action of the heart and tension of the vessels, is one of the most characteristic signs of pericardial effusion. Intensification of the second sound over the aortic area is at times quite marked. If, during the course of acute articular rheumatism, the heart becomes irritable, with palpitation and precordial pain, it should be carefully and frequently examined. Your examinations may be negative, and then you will find a friction sound developing, or you may find suddenly all the evidences of extensive effusion, or the effusion may come on gradually, displacing the friction sound, or the friction may remain, the dulness gradually increasing.

There are other forms of pericardial inflammation which may be confounded with conditions not mentioned, but they do not properly come within the bounds of this paper. Chronic pericarditis with adhesion of pericardial surfaces may result from the acute form; this occurs where there is considerable plastic effusion. This may not disappear as rapidly as a sero-fibrinous or serous effusion; the young connective tissue organizes rapidly, until there may be a firm mass of fibrous tissue surrounding the heart. The parietal layer is usually more thickened than the visceral; the two may be bound together by bands of tissue, or they may be almost entirely agglutinated; the epicardium may be transformed into plates or masses of bony hardness. The possibility of this condition must be borne in mind in making a prognosis where recovery is slow, as the additional labor imposed on the heart under the circumstances may cause hypertrophy.

Various signs have been given as diagnostic of this condition, such as a lack of alteration in the area of

percussion dulness in inspiration and expiration, sinking in of intercostal spaces, and end of sternum with systole of heart; but there are no characteristic signs of this condition.

The treatment is, to a large extent, symptomatic. In recent cases of rheumatic pericarditis, it is well to adopt an expectant line of treatment. If the onset is active with great pain, the local application of a dozen leeches will give great relief. Digitalis, when the heart's action is labored, is very useful; it should be given carefully, and if myocarditis be present, very sparingly or not at all, as it would be impossible to give enough to be of any use without danger of toxic results. Iron and a nutritive diet are necessary. Iodide of potassium, with the bicarbonate (when the more active rheumatic trouble has already been controlled), is very useful. Rest should be strictly enjoined until exercise can be taken without cardiac excitement. Paracentesis should be performed when pressure from the effusion causes great dyspnoea, or interferes greatly with the action of the heart. The operation may be performed with a trocar, by incising the skin in the fifth intercostal space about an inch from the left edge of the sternum, and passing in the trocar; the stylet should be sheathed as soon as the pericardium is reached; the trocar being passed obliquely, the canula can then be pushed further in, if necessary. The aspirator is the preferable instrument for this operation; a needle about one millimetre in diameter should be used; or if the diagnosis of the quantity and location of fluid is not clear, one-half as large as puncture of the heart would then probably cause no trouble. The reversible aspirator, with siphon attachment, is preferred by some, as the fluid may be flaky and obstruct the needle, in which instance the action may be reversed and the needle cleared without removal. The patient may be in the sitting or recumbent position. The precise spot for introduction of the needle varies according to the ideas of the operator. Some prefer the fifth interspace, an inch or inch and a half from left edge of sternum; others prefer the very apex of the space between the free end of the sternum and the cartilage of the ribs. This is a good point in proper cases, the diaphragm is attached just above this point, but the weight of a considerable effusion may push it down sufficiently to allow a needle inserted in the apex of this space to pass through its tendinous insertion into the pericardium. The space existing between the muscular slips, which attach the tendinous insertion of the diaphragm to the cartilages of the ribs on either side, and which is filled by areolar tissue, probably lessens the resistance at this point, and allows the pericardial sac to descend lower than it otherwise would; but with a small effusion it would probably be easier to obtain fluid in the fifth interspace. As soon as the point of the needle is well engaged in the tissues, the stop-cock should be opened, allowing the vacuum to extend to the needle point, as the first intimation of being into the sac may be the presence of fluid in the tube. As a rule, however, the sensation of non-resistance conveyed to the hand in pushing the needle, will tell plainly when the pericardial space is entered. Be-

tween sixteen and eighteen ounces of fluid have been removed at one aspiration. The instruments should be aseptic, and care should be taken that they be in good working order. This operation may be demanded simply as a palliative in cases where death must shortly ensue, and the relief obtained from it fully justifies the small risk which may attend it.

A CASE OF ENORMOUS FIBRO-CYSTIC TUMOR OF THE UTERUS.

LAPAROTOMY—RECOVERY.

BY X. O. WERDER, M.D.,
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JUNE 14 last, I was consulted by Miss W. C., aged twenty-three, in regard to an abdominal tumor which had been growing for the last eight months. The abdomen was enlarged to the size of pregnancy at full term, and below the umbilicus were a number of striae, such as you find at the end of gestation. The right side of the abdomen was more rounded than the left, the tumor apparently having developed from that side. Dulness extended from the pubes to the ensiform cartilage, and to both hypochondriac regions, leaving a tympanitic area in both flanks. The tumor was uniform, soft and elastic, and distinctly fluctuating. The largest circumference of the abdomen was between the umbilicus and pubis. Digital examination per vagina revealed a normal nulliparous cervix, high up in vagina; fundus uteri could not be felt; sound was not introduced. Vaginal examination very difficult and painful on account of a rather rigid hymen. Examination per rectum negative.

Miss C. first menstruated at thirteen years, always regular and painless, lasting five days. Has been more profuse since appearance of tumor than before. Had typhoid fever five years ago, then dyspepsia for a time after, but not since. Was confined to bed with rheumatism eight weeks; otherwise in good health. No sign of tumor until eight months ago, and then it was only noticeable about two weeks before each menstruation, when she felt bloated; this feeling always disappeared before the next menstrual period. She was not conscious of the tumor, however, until two or three months before the operation. The tumor never gave her any trouble except about two weeks after each menstruation, when it always became distinctly larger, making her quite uncomfortable. From this history, and from the fact of the rapid growth of the tumor, and its apparent development from the right side, I did not hesitate to pronounce it an ovarian cyst. Several physicians of ability, who had examined the case before I did, had already made the same diagnosis.

June 24, I opened her abdomen at Mercy Hospital. The tumor was covered by a fold of the peritoneum, traversed by a large number of bloodvessels, some of them of enormous size, and studded by numerous small cysts. It was at first rather difficult to determine whether this was the omentum adherent to the tumor, or some other structure, but on pushing my hands down between the tumor and the abdominal

walls, I could feel it spread out on each side of the tumor like two wings. There was, therefore, no doubt that it was the broad ligament which was enveloping the lower portion of the tumor. This fact, in addition to the tumor—which though even now distinctly fluctuating, seemed to have a thick-set muscular wall, a fold of which, picked up between the thumb and finger, felt like the walls of an enlarged pregnant uterus—made it evident that the growth was something else than an ovarian cyst: that it was either a pregnant uterus or a soft tumor growing from the uterus. A hypodermic needle was passed into the tumor, but nothing but a few drops of serous fluid was withdrawn. Pregnancy was excluded on account of her regular menstruation, rigid hymen and virginal condition of vagina and cervix, appearance of her breasts, absence of foetal sounds and ballottement, etc. Concluding that we had to deal with a myoma, we proceeded to deliver it. This, however, was a difficult task. The abdominal incision was enlarged above and below, some adhesions to bowels and abdominal parietes were tied off as they were encountered, but all attempts to deliver the tumor failed until the incision had been carried up to the ensiform cartilage. By all these manipulations a great deal of time had been consumed before the tumor had been rolled out of the abdominal cavity, and the hemorrhage was alarming because of the extremely vascular nature of the tumor. The patient had become very anæmic, and at times almost collapsed, requiring constant stimulation by hypodermic injections of whiskey, of which she received from thirty to forty during the operation. The broad ligaments, the right of which reached higher on the tumor than the left, and folds of peritoneum connecting the bladder and the tumor were now separated from the tumor as far as necessary to form a pedicle, and were secured by small forceps and an elastic ligature passed tightly around the tumor, just above the attachment to the fundus uteri, and the myoma cut off above the ligature. After trimming the pedicle, which was about the size of two fists, it was brought into the lower angle of the abdominal wound, and the parietal peritoneum stitched to it just below the elastic ligature, in order to shut it off from the peritoneal cavity. The broad ligaments and the peritoneal folds, secured by the artery clamps, were also brought out below the pedicle; the forceps, six in number, were not removed, but were wrapped in iodoform gauze. In the absence of proper instruments for extra-peritoneal treatment of the pedicle—I having been prepared for an ovariotomy only, and not for a myomectomy—I compressed the upper part of the pedicle by two large Spencer Wells' forceps, one on each side, covering their handles with iodoform gauze. They were made to take the place of the clamps ordinarily used in the treatment of the pedicle by the extra-peritoneal method. The abdominal wound was then closed by silk-worm gut sutures, deep and superficial, a glass drainage tube was inserted immediately above the pedicle, the wound was covered with iodoform, and an antiseptic dressing was applied. The pedicle was seared with the actual cautery and covered with iodoform.

The patient rallied well from the shock of the operation. On the first evening temperature was 102° , pulse 120; afterward the temperature never reached that point again, and became normal after the first week. The patient suffered very little pain, except from flatulence the first few days; the large Spencer Wells' forceps attached to the pedicle gave her most of her trouble, as they prevented her from turning on either side, keeping her constantly in the dorsal position. The drainage tube was removed about thirty hours after the operation. The small artery forceps attached to broad ligaments and peritoneal folds were removed on the seventh day; large Spencer Wells' forceps on the eleventh day on one side and on the thirteenth day on the other; the elastic ligature came away with the pedicle on the nineteenth day, leaving a large funnel-shaped opening, covered with healthy granulations. There was never any suppuration from the pedicle, it becoming dry and mummified, but on the twelfth day a small fecal fistula formed on the side of the pedicle, discharging small quantities of fecal matter at first, which ceased, however, after about ten days, nothing but some flatus coming from it now occasionally. Abdominal incision was healed by first intention when sutures were removed on tenth day.

There is now, eight weeks after the operation, only a small granulating surface left at the seat of the pedicle, not larger than a five-cent piece, which is rapidly cicatrizing. The patient has gained flesh since the operation, and feels perfectly well, so that she will be able to leave for her home in Ohio in a few days.

The tumor weighed twenty-six pounds, not including the pieces cut away in trimming the pedicle; they, in connection with the blood lost during the operation, would have probably increased its weight to forty pounds. The tumor was a fibro-cyst, but contained large cystic cavities; it presented rather an oedematous, spongy condition. Even when lying on the table distinct fluctuation could be obtained, and on its cut surface small drops of serous fluid were observed, like drops of sweat. No microscopical examination of the tumor was made; I had intended to harden it in alcohol and preserve it, but the weather was intensely hot, and it spoiled in a few days.

The interesting points of this case are: 1, the youth of the patient; tumors of this kind are rarely found at a less age than thirty-five; 2, the rapidity of its growth; it attained this enormous size in eight months, without causing much local or constitutional disturbance; 3, its distinct increase in size always two weeks after each menstruation; periodical enlargement of fibroid tumors is not uncommon, but this occurs generally during menstruation. The question naturally suggests itself whether swelling of the growth in this case did not correspond to the time of ovulation.

That a diagnosis of ovarian cyst was made in this case is not surprising. The fact is that it is impossible to differentiate fibro-cystic tumors of the uterus, especially when of such large size as this, from ovarian tumors, as all the physical signs are almost identical. Gusserow, in his book on fibroids of the

uterus, "Encyclop. Obstetrics and Gynæcology," says: "The diagnosis of these tumors has only been made in the most exceptional cases, and even then has been the result of accident rather than of correct appreciation of the symptoms. Fibro-cysts so closely resemble multilocular ovarian cysts, particularly in their location and in their fluctuation, that the frequency with which they have been mistaken for ovarian tumors is not astonishing."

BRIGHT'S DISEASE WITHOUT URINARY SYMPTOMS.

BY W. W. KNIGHT, M.D.

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THE physiological function of the kidneys would seem to be a comparatively simple one; mainly the excretion of urea with a small amount of other excrementitious matters, all being held in solution in a suitable amount of water. But when the kidneys become diseased and their function hindered or suppressed, we observe a variability in the resulting symptoms which hardly occurs in disease of any other organ.

The term Bright's disease includes several different pathological processes, but even where the disease process is apparently precisely the same, the systemic effect is manifested by a great diversity of symptoms. In some cases dropsy is the prominent symptom, in others it does not occur at all, in some cases convulsions or coma, in others sometimes headache, or eye troubles or dyspnoea, etc., none of them pathognomonic, and frequently all conspicuous only by their absence. In consequence of this variability we depend upon the urinary symptoms for a positive diagnosis. We look for changes in the amount and specific gravity of the urine, for albumen and casts, and finding them we are sure of our diagnosis. Their temporary absence is well known to be of not infrequent occurrence in cases of nephritis, but if after several examinations we find none of these urinary symptoms, the most careful of us ordinarily feel justified in excluding Bright's disease, and of course in the great majority of cases we make no mistake; but post-mortem examinations occasionally show that we do have cases of Bright's disease which run their course without at any time anything abnormal in the water being shown by more than ordinarily careful urinary examination. While our authorities all speak of the temporary absence of urinary symptoms, the only one I have seen who refers to their persistent absence is Porter, and he merely refers to it casually as one of the possibilities in this disease. So little is written on this point, and so seldom is it referred to, that it has seemed to me worth while bringing it before this Society for discussion, by the relation of two cases in which an autopsy showed the existence of nephritis, but where frequent examinations of the water for some time before death, failed to detect anything abnormal; no albumen, no casts, specific gravity normal and the amount in due proportion to the amount of fluid ingested.

CASE I.—Was that of a woman whom I was called to see December 15th, 1888. She had been taken

sick in the preceding September, with inflammatory rheumatism. Under homoeopathic treatment, this ran its usual course of five or six weeks. During this time there had been little actual vomiting, but considerable nausea and inability to take food. After the subsidence of the inflammatory symptoms the patient did not recover strength and was still confined to her bed. She continued in this condition with no prominent symptoms except loss of strength and flesh, until about the first of December, when persistent vomiting became a marked symptom, and after a little the vomited matter became bloody. During this time the water was frequently tested for albumen, but none found. It was somewhat scanty and at times of rather low specific gravity, but never persistently low and the amount as much as would be expected in a person taking as little nourishment. When I visited her I found persistent vomiting, the ejected matters frequently containing blood. The patient was much emaciated; pulse and temperature normal, no symptoms of any brain trouble. The hematemesis of course led to suspicion of gastric cancer, but no tumor could be detected, neither was there the severe pain indicative of cancer. In short, there were no symptoms except the gastric ones, and the great weakness that would naturally follow upon an almost complete inability to take food for three months. During the last ten weeks of this time she had been nourished solely by enemata of beef tea.

A specimen of the water showed a specific gravity of 1020, contained no albumen and no casts. Subsequent specimens gave the same results. After a few days the vomiting lessened and the hematemesis stopped, but the patient died of pure exhaustion, December 25th, 1888.

At the post-mortem examination, nothing was found abnormal in the stomach except a slight congestion. The heart was slightly hypertrophied, the kidneys were a little smaller than normal, dark red in color, firm in texture, capsule easily removed, but tearing slightly the surface of the kidney, which was slightly granular, cortical portion diminished in size, striations indistinct. These changes thus indicate typically the contracting stage of a chronic interstitial nephritis. The brain was not examined.

CASE II.—Was that of a patient of Dr. Storrs, to whom I am indebted for the following ante-mortem history: Male, aged 62, first seen in June, 1887; was called on account of vomiting. The patient was pale, sallow, and anaemic; had not felt quite up to usual condition for some time previous, but had not been sick enough to consult a physician. There were no symptoms aside from the vomiting, which was obstinate. The urine was examined, with negative results; no albumen, no casts, specific gravity 1018; the amount about two pints, as much as would be expected where the stomach was retaining so little. After a time there was some improvement, and the patient spent the summer at different health resorts, but was subject to frequent attacks of vomiting. At no time was there dropsy or any other symptom of Bright's disease. During the winter the vomiting became more troublesome, and the patient died of simple exhaustion in March, 1888. During these

nine months the water was frequently examined, both chemically and microscopically, and at no time was the least abnormality detected. At the request of Dr. Storrs I made an autopsy with the following results: Body fairly well nourished; heart, lungs and stomach normal; no hypertrophy of the heart; the kidneys were enlarged, capsule easily removed, surface smooth, cortical portion increased, light colored, presenting all the appearances of the second stage of chronic interstitial nephritis, commonly called "large white kidney."

It is unnecessary to relate in detail two other autopsies I have made to determine the cause of death resulting from persistent vomiting, and found that the cause was Bright's disease. The urine in these cases had been frequently examined for some time previous to death, with negative results.

These four cases are illustrations of that class to which I wish to call your attention, and they seem, too, not to be so very uncommon. It would be idle to deny that albumen and casts might have been found at some time in the course of the disease in these cases, but the water was examined much more frequently than we ordinarily do such work, so that for diagnostic purposes, at least, they may fairly be called cases of Bright's disease, running their course without urinary symptoms. Case II is especially interesting, in that it presented the large white kidney, a form of Bright's disease in which we are most certain to get a large amount of albumen. None of these were cases of true cirrhotic kidney, where we get a large amount of water of a low specific gravity, with little, and frequently no, albumen.

Just how to explain a case of Bright's disease, running its course without the appearance of albumen and casts in the water, is a difficult matter. The explanation usually given by writers, of the temporary absence of these symptoms, namely: that the diseased tubules are so completely plugged with casts that no urine is secreted by those tubules, and so no albumen and casts can reach the water, may, possibly, apply to these cases.

All of the cases to which I have referred were cases of protracted vomiting. We would be hardly justified in concluding from this that these are the only cases in which there is absence of albumen and casts. Such cases become prominent, because we are more apt to get a post mortem examination in such cases, by reason of the persistent vomiting being such a prominent symptom. I think it very probable that some other fatal cases of obscure troubles are cases of Bright's disease without albumen or casts in the water. I have never made an autopsy in such a case, but I have seen deaths from convulsions, for example, where nothing was found wrong with the water, but where it seemed as if nothing else than Bright's disease could be the cause of the symptoms.

The immediate cause of the symptoms, especially the vomiting, in such cases as have been related, is obscure. The post-mortem examination showed no local trouble with the stomach, and the peculiar character of the vomiting is indicative of the constant action on the nerve centers of some chemical toxic substance. In common parlance we call this condition

uræmia, but no one at the present day believes that it is due simply to the retention in the blood of urea, and in the cases related the amount and specific gravity of the urine indicate, when we consider the amount of food retained, the elimination of a proper amount of urea. When the true explanation does come, it will very likely locate the trouble somewhere in that complex series of changes by which the nitrogenous elements of the body are converted into urea and uric acid. Preceding or accompanying the formation of these final substances, there are produced numerous little known alkaloids named leucomaines, some of them poisonous, others requiring little chemical change to render them toxic. Under normal conditions we either excrete or further oxidize these toxic bodies into harmless substances, but in Bright's disease we may suppose that this metabolic process is interfered with in some way, so that some poisonous alkaloid accumulates in the system in quantity sufficient to cause the symptoms we call uræmia. If we put the cause here, we can see why our ordinary eliminative treatment, especially in these cases where apparently a normal amount of solid material is excreted, is of so little benefit, and I think you will all agree that these vomiting cases are most difficult to benefit.

In regard to the diagnosis of these cases, it is not easy to be positive. Here the practically pathognomonic symptoms of albumen and casts fail, as we must depend on the general appearance of the case, and especially upon the exclusion of other diseases. To a certain extent, the character of the vomiting is diagnostic. It would be difficult to mention another disease in which such continuous and persistent vomiting, nausea and retching stand alone as the prominent symptoms. The patient gets no relief; vomits whenever anything is taken into the stomach, or when a little mucus accumulates there. During all this there is not the pain of gastric ulcer, nor the pain and tumor of cancer. Hematemesis is not common, but does sometimes occur, as in case I. In sixty-eight cases of chronic Bright's disease, described by Dickinson, it was present in only three. By excluding other causes, and paying attention to the character of the vomiting, we shall be able, in many cases, to make at least a probable diagnosis.

Allied to these cases of complete absence of albumen and casts, are those cases where these symptoms are temporarily absent. This is well illustrated by a case now under my charge. I was called to see a woman on account of vomiting. There was no edema, no brain symptoms, in fact, nothing except the vomiting. I examined a specimen of the water and found it normal. The vomiting persisting, two days later I examined another specimen and found an abundance of albumen and casts; two days later another specimen showed no albumen, and only a few casts. Such cases are common, and are referred to only for the purpose of calling attention to the necessity of making several examinations of the urine, in doubtful cases. The results of post-mortem examinations have shown me that this necessity is sometimes overlooked.

There is another class of cases where renal com-

plications are apt to pass unnoticed. This includes those people, especially elderly persons, whose kidneys perhaps cannot be called diseased, but in whom these organs are, during health, worked to their full capacity in order to excrete all effete material. In this condition, when some acute disease comes, and sometimes only a very slight trouble, the kidneys are unable to do the extra work required in eliminating the increased amount of excrementitious materials, and an acute parenchymatous nephritis is set up, which becomes an important factor in the case. Unless the water is thoroughly examined, these persons seem to die from very slight causes.

I have brought forward this subject, not for the purpose of saying anything new or original, but because the making of post-mortem examinations had shown me that Bright's disease is frequently overlooked, sometimes no examination of the water had been made, sometimes because only one specimen had been examined, and sometimes in those more rare and more excusable cases where there had been no urinary symptoms.

Hydrotherapeutics.

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Omission.—In describing the technique of Brand's method in the last article, a serious omission occurred which I desire to rectify. During the continuance of the bath, a pitcher or basinful of the bath water should be gently poured upon the patient's head and allowed to flow over his neck and shoulders while he is held in a half-sitting posture. To prevent the water running over the face, which is unpleasant, a napkin or large handkerchief should be made into a bandage after folding it into a triangle. The middle portion passing over the forehead, the ends are tied upon the nucha, forming a trough, as it were, which leads the water poured upon the head down upon the neck and shoulders. This gentle affusion should be repeated twice during the bath. As the patient emerges from the bath a large basinful of colder water should be poured over his shoulders for the stimulating effect, which aids in producing reaction.

These affusions are an important element of the Brand bath, and should never be omitted.

VI.

QUERIES AND OBJECTIONS ANSWERED.

CONTRA-INDICATIONS CONSIDERED.

THE intelligent student of the cold-bath treatment of typhoid fever, finds himself perplexed by many questions which imperatively demand solution, when he is called upon to make an actual clinical demonstration at the bedside.

To forestall these difficulties, which the reader will surely encounter, and enable him to overcome them, I propose to discuss several queries and objections, which correspondence, personal experience and discussion have brought to my attention.

Is the rule to bathe every three hours in winter, at 65° F., whenever the temperature reaches 103° F., absolute, and not to be modified to adapt it to each case? Most assuredly, I would never deviate from the rule, with one exception (noted below), because this rule has been established by deduction from large clinical material, carefully gathered by numerous observers in different localities in private, hospital, and in military practice. It must always be borne in mind, too, that the object of the bath is prophylactic; its aim is not a mere reduction of temperature, but a suppression of the violence of the febrile movement until it has spent its force.

Whoever expects to throttle the fever by the bath will surely be disappointed, for its course is as steady and inexorable as any law of nature. The temperature will almost invariably fall from one to three degrees after each bath, only, however, to rise again to within a fraction of its former rate when the three-hourly examination is made. But from day to day there will be a gradual, yet steadfast diminution of the *average temperature*, which indicates that the resisting power of the system is gaining sway over the disease. This is the usual effect of the systematic cold bath, administered without fear and without favor. Whenever we attempt to substitute another form of hydriatic procedure, to raise the temperature of the bath water, to shorten the duration of the bath, or otherwise to change the rule, we must expect a change in the result. If the case comes under treatment late, the resisting power of the disease will be greater, hence the result of the bath will deviate from that here depicted. The type of severity of the disease, too, will exert its influence upon the latter. If the temperature fails to be favorably influenced by the systematic baths at 65° , a lower temperature, not below 60° , will be found useful in the first two weeks of the disease. Occurring later, a persistently high temperature will probably be due to complications, in the prevention of which the systematic cold bath has far more influence than in their treatment. One point should be ever present in the mind of the attendant—viz., the chief aim of the cold bath is to endow the system with power to resist the disease; hence it is all important to begin it early, and not to expect so much (though still a considerable effect) from it, when the disease has already made decided inroads upon the blood and the vital organs.

One correspondent has said that "this is a very delicate adjustment of treatment, when a patient is saved or doomed, according as it is inaugurated on the fourth or fifth day." As I have elsewhere said, this objection, if valid, would apply to much of our therapeutic endeavor. *Obsta principiis* is the first principle of rational therapeutics. Disease has often been likened to a conflagration, the ease of whose subdual is in proportion to the stage at which it is attacked. In the severe types of malarial fever, for instance, one day's—yes, even one hour's—cinchonization may save the patient's life; its delay doom him to death, or to a long-continued invalidism. Brand has demonstrated as clearly as anything can be demonstrated by clinical data, not from his own prac-

tice only, but from that of others also, that *out of two thousand cases treated before the fifth day not one died*. The uncertainty of diagnosis here steps in to mar possible success. Before the appearance of the spots, we cannot pronounce definitely whether we have a case of typhoid fever, acute tuberculosis, gastric fever, pneumonia, acute nephritis, or one of the exanthemata. We have the satisfaction of realizing, however, that in the large proportion of cases these diseases may readily be excluded. But we may escape from the dilemma entirely if we adopt the rule laid down in the early portion of this series, to subject every case of fever whose temperature persistently marks as above 103° , for several hours, to cold bathing in a mild form. Experience has taught that no harm will ensue from such a course. The systematic bath may aid us in reaching a diagnosis. In acute tuberculosis, for instance, the symptoms will not be ameliorated as in typhoid, and even if the bath were capable of damaging the patient's prospects, the latter cannot be done, because the disease is invariably fatal. In the low forms of the initial stage of some of the exanthemata, with high temperature, cold affusions have been found so effective by Currie, and later by Ziemssen and others, that a few ablutions or baths will surely not damage the patient's chances, but rather rescue him from the ataxic condition and save his life.

All cases of typhoid fever should be subjected to the bath. One correspondent asks "if a patient has a temperature of 104° for an hour or two every evening, but with moderate fever for the rest of the time, and without 'Functionsstoerung,' should you then think it necessary to insist upon the bath?" This is a question that will frequently arise in the mind of the practitioner, who would fain shrink from the trouble, annoyance and possible criticism of the bath procedures, so long as the case presents a mild aspect. It will not be difficult for the attendant to order and insist upon the cold bath, if the patient has a temperature of 105° , with delirium, stupor, but when he appears to be comfortable, with a temperature ranging from 102° to 103° , or 104° , it does seem so glaring a violation of the long-established expectant treatment, to disturb his comfort by a cold bath, that few men will have the temerity to advise it. The experienced practitioner, however, knows, but too well, how sadly his prognosis, derived from an early, mild course, sometimes fails to be verified, when, in the beginning of the third week, the first sound of the heart begins to fail, the pulse becomes rapid, the lung becomes hypostatic, hemorrhage, perforation, and death close the scene. We rarely witness the death of a case of typhoid in the first week from excessive temperature or from failure of the nervous system; the chief danger lies in the infective process, which undermines the system slowly but surely. To meet this danger, the cold bath is our shield and ever-ready weapon. In mild cases, the rise of temperature and pulse are readily combated by it; the resisting power of the disease is feeble. Hence the temperature rises only at long intervals to 103° F., but whenever it does so rise, the rule should be inexorable; the bath must be administered. Clinical ex-

perience demands it, and if we would receive its benefits we must obey the behest.

Is there not danger of producing lung complications by cold bathing? This question has also been abundantly answered by clinical demonstration. There can be no more threatening conditions than exist in the military hospital of Vogl, in Munich. If a combination of cold air and very cold baths do not produce bronchitis, pneumonia and pleurisy in typhoid fever, the bath alone may be regarded as free from such accusation. Vogl places his infectious cases in barracks, which are built of wood, as summer pavilions, resting upon pillars, which support a double floor, whose ventilation is complete; the roof, ceiling and walls are also arranged for perfect circulation of air.

During the severest part of the winter he closes the open spaces under the roof and between the floors by simple boarding up, and starts a fire in the cast-iron stoves, *all the windows remain open*, unless strong winds, rain or snowdrift forbid, which the neighboring buildings somewhat prevent. The patient is only protected against direct drafts of cold air; the windows adjoining the tubs are always closed. As the entire length of the barracks consists of windows, without intervening walls, the patients practically lie in the open air. "In severe weather we rarely can raise the temperature above 0 C. (32° F.). The fear of cold and circulating air is unjustified. I am so accustomed to hear from my visitors expressions of apprehension on the point, that I do not wonder if the reader feels the same. Just as I have convinced the former, so I hope to convince the latter, that a thorough lung ventilation protects against adhesive processes; the cooling effect of the cold air and increase thereby of heat dissipation from the whole body, forms together with the baths the basis for our success. An experience of ten years' conscientious observation without prejudice is surely entitled to consideration. I have never heard complaints nor experienced anything but benefit from the extensive and thorough ventilation of our barracks, and I feel that I have not departed from the useful. Bronchial catarrh, angina, are just as rare here as in the large wards; we have never seen severe erysipelas. A very anaemic, pleuritic patient, who was sent to the barracks with a sub-febrile temperature, was transferred into the large ward when cold weather commenced. His temperature rose at once and remained high for five days, with strong morning remission. The high temperature ceased at once on his being returned to the barracks. The unpleasant effect upon the anaemic patient, but not upon the accompanying bronchitis, drove him back to the ward, where his temperature again rose, so that he asked to be transferred to the barrack, where he recovered. There was not a single death from pneumonia or bronchitis, and only one from pleurisy, in cases treated by strictly cold bathing and this open-air method. I could cite much other striking testimony on this point, but none more convincing, I trust."

On the contrary, so far from producing lung complications, the numerous cases detailed in extenso by Brand, and by Tripier and Bouveret and others, go

to prove that we have in the cold bath the most effective treatment of these complications, when they occur *during* typhoid fever. Only when they occur in far advanced stages of the fever with great adynamia, the cold bath should be exchanged for that of a milder temperature and more brief duration.

Many complications arising in the course of the disease may cause the practitioner to pause in the strict pursuit of the cold bath treatment. The work of Tripier and Bouveret refers to these in extenso, entering upon the discussion of each so minutely that it is a mine of information from which I draw on this subject, because there exists no English translation.

Nose-bleed is not a contraindication; even in severe cases it usually ceases after bathing. *Hæmoptysis* is so rare that it occurred only eleven times in five thousand cases. If it occurs in an advanced stage of the disease, or with cyanosis and pronounced heart feebleness, it is well to desist from cold baths, even if there be a high temperature and severe cerebral symptoms, which is a rare occurrence.

In the early stages a bloody or streaked expectoration does not forbid the bath.

The Polyclinic.

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PULSATATING BRONCHOCELE.

WAUGH presented at his clinic a case of pulsating bronchocele. The left lobe was much larger than the right. The upper central part presented a heaving pulsation, a thrill, and a bruit heard on auscultation, which he described as typical of the signs of aneurism. They came, however, from a part of the goitrous mass, which rose upon the patient's swallowing; and there were none of the pressure symptoms of aneurism present. The lecturer stated that there was probably a dilated condition of the arteries present; probably an anastomotic aneurism of this portion of the gland. He recommended the use of iodine internally and externally, and the injection of an ointment of biniodide of mercury in lanoline; to be applied twice a week, the patient to expose the neck to the rays of the sun for an hour afterwards. The condition of the bloodvessels rendered the use of coagulating injections dangerous, while removal of the tumor would probably be followed by the occurrence of myxoedema. He considered the safest treatment to be that he then prescribed.

MT. SINAI HOSPITAL, NEW YORK.

PARAMETRITIC ABSCESS AND INCISION.

IN this case of parametric abscess, I call your attention to its large size, its high situation in the iliac fossa extending nearly up to the lower ribs, and to the fact that it cannot be felt from the vagina.

The treatment is very simple. Incision; a drainage-tube will be inserted, the cavity irrigated with an antiseptic solution; in a few days the tube will be removed, and the cavity packed with iodoform gauze; left to heal by granulation.

—Prof. Paul F. Mundt.

sick in the preceding September, with inflammatory rheumatism. Under homoeopathic treatment, this ran its usual course of five or six weeks. During this time there had been little actual vomiting, but considerable nausea and inability to take food. After the subsidence of the inflammatory symptoms the patient did not recover strength and was still confined to her bed. She continued in this condition with no prominent symptoms except loss of strength and flesh, until about the first of December, when persistent vomiting became a marked symptom, and after a little the vomited matter became bloody. During this time the water was frequently tested for albumen, but none found. It was somewhat scanty and at times of rather low specific gravity, but never persistently low and the amount as much as would be expected in a person taking as little nourishment. When I visited her I found persistent vomiting, the ejected matters frequently containing blood. The patient was much emaciated; pulse and temperature normal, no symptoms of any brain trouble. The hematemesis of course led to suspicion of gastric cancer, but no tumor could be detected, neither was there the severe pain indicative of cancer. In short, there were no symptoms except the gastric ones, and the great weakness that would naturally follow upon an almost complete inability to take food for three months. During the last ten weeks of this time she had been nourished solely by enemata of beef tea.

A specimen of the water showed a specific gravity of 1020, contained no albumen and no casts. Subsequent specimens gave the same results. After a few days the vomiting lessened and the hematemesis stopped, but the patient died of pure exhaustion, December 25th, 1888.

At the post-mortem examination, nothing was found abnormal in the stomach except a slight congestion. The heart was slightly hypertrophied, the kidneys were a little smaller than normal, dark red in color, firm in texture, capsule easily removed, but tearing slightly the surface of the kidney, which was slightly granular, cortical portion diminished in size, striations indistinct. These changes thus indicate typically the contracting stage of a chronic interstitial nephritis. The brain was not examined.

CASE II.—Was that of a patient of Dr. Storrs, to whom I am indebted for the following ante-mortem history: Male, aged 62, first seen in June, 1887; was called on account of vomiting. The patient was pale, sallow, and anaemic; had not felt quite up to usual condition for some time previous, but had not been sick enough to consult a physician. There were no symptoms aside from the vomiting, which was obstinate. The urine was examined, with negative results; no albumen, no casts, specific gravity 1018; the amount about two pints, as much as would be expected where the stomach was retaining so little. After a time there was some improvement, and the patient spent the summer at different health resorts, but was subject to frequent attacks of vomiting. At no time was there dropsy or any other symptom of Bright's disease. During the winter the vomiting became more troublesome, and the patient died of simple exhaustion in March, 1888. During these

nine months the water was frequently examined, both chemically and microscopically, and at no time was the least abnormality detected. At the request of Dr. Storrs I made an autopsy with the following results: Body fairly well nourished; heart, lungs and stomach normal; no hypertrophy of the heart; the kidneys were enlarged, capsule easily removed, surface smooth, cortical portion increased, light colored, presenting all the appearances of the second stage of chronic interstitial nephritis, commonly called "large white kidney."

It is unnecessary to relate in detail two other autopsies I have made to determine the cause of death resulting from persistent vomiting, and found that the cause was Bright's disease. The urine in these cases had been frequently examined for some time previous to death, with negative results.

These four cases are illustrations of that class to which I wish to call your attention, and they seem, too, not to be so very uncommon. It would be idle to deny that albumen and casts might have been found at some time in the course of the disease in these cases, but the water was examined much more frequently than we ordinarily do such work, so that for diagnostic purposes, at least, they may fairly be called cases of Bright's disease, running their course without urinary symptoms. Case II is especially interesting, in that it presented the large white kidney, a form of Bright's disease in which we are most certain to get a large amount of albumen. None of these were cases of true cirrhotic kidney, where we get a large amount of water of a low specific gravity, with little, and frequently no, albumen.

Just how to explain a case of Bright's disease, running its course without the appearance of albumen and casts in the water, is a difficult matter. The explanation usually given by writers, of the temporary absence of these symptoms, namely: that the diseased tubules are so completely plugged with casts that no urine is secreted by those tubules, and so no albumen and casts can reach the water, may, possibly, apply to these cases.

All of the cases to which I have referred were cases of protracted vomiting. We would be hardly justified in concluding from this that these are the only cases in which there is absence of albumen and casts. Such cases become prominent, because we are more apt to get a post mortem examination in such cases, by reason of the persistent vomiting being such a prominent symptom. I think it very probable that some other fatal cases of obscure troubles are cases of Bright's disease without albumen or casts in the water. I have never made an autopsy in such a case, but I have seen deaths from convulsions, for example, where nothing was found wrong with the water, but where it seemed as if nothing else than Bright's disease could be the cause of the symptoms.

The immediate cause of the symptoms, especially the vomiting, in such cases as have been related, is obscure. The post-mortem examination showed no local trouble with the stomach, and the peculiar character of the vomiting is indicative of the constant action on the nerve centers of some chemical toxic substance. In common parlance we call this condition

uraemia, but no one at the present day believes that it is due simply to the retention in the blood of urea, and in the cases related the amount and specific gravity of the urine indicate, when we consider the amount of food retained, the elimination of a proper amount of urea. When the true explanation does come, it will very likely locate the trouble somewhere in that complex series of changes by which the nitrogenous elements of the body are converted into urea and uric acid. Preceding or accompanying the formation of these final substances, there are produced numerous little known alkaloids named leucomaines, some of them poisonous, others requiring little chemical change to render them toxic. Under normal conditions we either excrete or further oxidize these toxic bodies into harmless substances, but in Bright's disease we may suppose that this metabolic process is interfered with in some way, so that some poisonous alkaloid accumulates in the system in quantity sufficient to cause the symptoms we call uræmia. If we put the cause here, we can see why our ordinary eliminative treatment, especially in these cases where apparently a normal amount of solid material is excreted, is of so little benefit, and I think you will all agree that these vomiting cases are most difficult to benefit.

In regard to the diagnosis of these cases, it is not easy to be positive. Here the practically pathognomonic symptoms of albumen and casts fail, as we must depend on the general appearance of the case, and especially upon the exclusion of other diseases. To a certain extent, the character of the vomiting is diagnostic. It would be difficult to mention another disease in which such continuous and persistent vomiting, nausea and retching stand alone as the prominent symptoms. The patient gets no relief; vomits whenever anything is taken into the stomach, or when a little mucus accumulates there. During all this there is not the pain of gastric ulcer, nor the pain and tumor of cancer. Hematemesis is not common, but does sometimes occur, as in case I. In sixty-eight cases of chronic Bright's disease, described by Dickinson, it was present in only three. By excluding other causes, and paying attention to the character of the vomiting, we shall be able, in many cases, to make at least a probable diagnosis.

Allied to these cases of complete absence of albumen and casts, are those cases where these symptoms are temporarily absent. This is well illustrated by a case now under my charge. I was called to see a woman on account of vomiting. There was no oedema, no brain symptoms, in fact, nothing except the vomiting. I examined a specimen of the water and found it normal. The vomiting persisting, two days later I examined another specimen and found an abundance of albumen and casts; two days later another specimen showed no albumen, and only a few casts. Such cases are common, and are referred to only for the purpose of calling attention to the necessity of making several examinations of the urine, in doubtful cases. The results of post-mortem examinations have shown me that this necessity is sometimes overlooked.

There is another class of cases where renal com-

plications are apt to pass unnoticed. This includes those people, especially elderly persons, whose kidneys perhaps cannot be called diseased, but in whom these organs are, during health, worked to their full capacity in order to excrete all effete material. In this condition, when some acute disease comes, and sometimes only a very slight trouble, the kidneys are unable to do the extra work required in eliminating the increased amount of excrementitious materials, and an acute parenchymatous nephritis is set up, which becomes an important factor in the case. Unless the water is thoroughly examined, these persons seem to die from very slight causes.

I have brought forward this subject, not for the purpose of saying anything new or original, but because the making of post-mortem examinations had shown me that Bright's disease is frequently overlooked, sometimes no examination of the water had been made, sometimes because only one specimen had been examined, and sometimes in those more rare and more excusable cases where there had been no urinary symptoms.

Hydrotherapeutics.

By S. BARUCH, M.D.,
Attending Physician New York Juvenile Asylum and Manhattan General Hospital.

Omission.—In describing the technique of Brand's method in the last article, a serious omission occurred which I desire to rectify. During the continuance of the bath, a pitcher or basinful of the bath water should be gently poured upon the patient's head and allowed to flow over his neck and shoulders while he is held in a half-sitting posture. To prevent the water running over the face, which is unpleasant, a napkin or large handkerchief should be made into a bandage after folding it into a triangle. The middle portion passing over the forehead, the ends are tied upon the nucha, forming a trough, as it were, which leads the water poured upon the head down upon the neck and shoulders. This gentle affusion should be repeated twice during the bath. As the patient emerges from the bath a large basinful of colder water should be poured over his shoulders for the stimulating effect, which aids in producing reaction.

These affusions are an important element of the Brand bath, and should never be omitted.

VI.

QUERIES AND OBJECTIONS ANSWERED.

CONTRA-INDICATIONS CONSIDERED.

THE intelligent student of the cold-bath treatment of typhoid fever, finds himself perplexed by many questions which imperatively demand solution, when he is called upon to make an actual clinical demonstration at the bedside.

To forestall these difficulties, which the reader will surely encounter, and enable him to overcome them, I propose to discuss several queries and objections, which correspondence, personal experience and discussion have brought to my attention.

Is the rule to bathe every three hours in winter, at 65° F., whenever the temperature reaches 103° F., absolute, and not to be modified to adapt it to each case? Most assuredly, I would never deviate from the rule, with one exception (noted below), because this rule has been established by deduction from large clinical material, carefully gathered by numerous observers in different localities in private, hospital, and in military practice. It must always be borne in mind, too, that the object of the bath is prophylactic; its aim is not a mere reduction of temperature, but a suppression of the violence of the febrile movement until it has spent its force.

Whoever expects to throttle the fever by the bath will surely be disappointed, for its course is as steady and inexorable as any law of nature. The temperature will almost invariably fall from one to three degrees after each bath, only, however, to rise again to within a fraction of its former rate when the three-hourly examination is made. But from day to day there will be a gradual, yet steadfast diminution of the *average temperature*, which indicates that the resisting power of the system is gaining sway over the disease. This is the usual effect of the systematic cold bath, administered without fear and without favor. Whenever we attempt to substitute another form of hydriatic procedure, to raise the temperature of the bath water, to shorten the duration of the bath, or otherwise to change the rule, we must expect a change in the result. If the case comes under treatment late, the resisting power of the disease will be greater, hence the result of the bath will deviate from that here depicted. The type of severity of the disease, too, will exert its influence upon the latter. If the temperature fails to be favorably influenced by the systematic baths at 65° , a lower temperature, not below 60° , will be found useful in the first two weeks of the disease. Occurring later, a persistently high temperature will probably be due to complications, in the prevention of which the systematic cold bath has far more influence than in their treatment. One point should be ever present in the mind of the attendant—viz., the chief aim of the cold bath is to endow the system with power to resist the disease; hence it is all important to begin it early, and not to expect so much (though still a considerable effect) from it, when the disease has already made decided inroads upon the blood and the vital organs.

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LAYING OF THE CORNER STONE OF THE NEW YORK ACADEMY OF MEDICINE.

WEDNESDAY afternoon, the 2d inst., was a red letter day in the medical history of New York. The ceremony of laying the corner stone of the New York Academy of Medicine, attracted a large audience to West 43d street, near Fifth avenue. A platform, erected upon the sidewalk and a portion of the street, was occupied by representative members of the profession, among whom were a fair sprinkling of the gentle sex. Within the foundation limits of the building another platform contained the President and Ex-Presidents of the New York Academy of Medicine, and of other local societies, besides Ex-President Cleveland, Bishop Potter, and the Rev. Dr. John Hall. Among the audience were noticed Mr. J. H. Schiff and a number of other philanthropic gentlemen, who are ever foremost in all good deeds.

Dr. Loomis introduced Bishop Potter, who offered a fervent invocation. He was followed by Dr. A. Jacobi, whose address recounted the struggles and aims of the New York Academy of Medicine in fitting terms, and made a manly appeal for support of an institution to which the lay public owes much more than the physician. He dwelt upon the great importance of thorough education of physicians, and urged laymen to be wary in their selection of medical attendants. The latter, he said, should not be chosen because he is an agreeable companion in the theatre or club, but with a view to his capacity for protecting the family against disease. The address was couched in that earnest and sound language and diction, which is the characteristic of Dr. Jacobi's utterances. It cannot fail to impress the public with a due sense of its interest in the erection and maintenance of the new academy.

Ex-President Cleveland made a favorable impression by his remarks, whose text was the importance

of aiding in the maintenance of the free institutions, to the existence of which we owe the possibility of erecting such shrines to Science. He said that physicians do not discharge their full duty by their devotion to their science alone, but that it is incumbent upon them also to give to political topics and movements the benefit of their trained thought and well-informed judgment. In this way alone, he claimed, the foundations upon which professional success rests, may be rendered secure. He hoped that, when the discovery of our continent shall be celebrated in this city two years hence, the completed academy building may be pointed out as a splendid monument of the progress of our medical education.

The corner-stone, upon which "N. Y. A. M., 1847-1889," is cut, was placed in position by Dr. Loomis, together with a box containing the documents relating to the academy. The new building will be a substantial but modest piece of architecture, five stories high, of modified Romanesque type. Its front will be of fine grained red sandstone and brick. Beside the large "Hosack Hall" (named in memory of Dr. Alex. Hosack, whose widow gave the academy \$70,000), whose dimensions will be 28 x 31 feet, and another hall of 42 x 57 feet, there will be some thirty-five other smaller rooms, and a number for the meeting of the sections. The library will have a capacity for 250,000 volumes. There is a prospect of having the building completed in a year. We wish the New York Academy of Medicine, whose discussions have added vastly to the progress of medical science, God speed.

MEDICAL ORATORY.

ONE of the reasons why students become drowsy and find it difficult to give continued attention to lectures is, as we have intimated in a previous editorial, that the brain and circulation have become sluggish in their actions from insufficient fresh air and outdoor exercise. But there is another explanation more forcible still—namely, the sluggish manner in which many lecturers deliver what they have to say. It is the same with speakers as with writers:

Un style trop égal et toujours uniforme
En vain brille à nos yeux, il faut qu'il nous endorme.

Once we enjoyed listening to a spirited debate upon the question of oratory in the pulpit. One side maintained that divine truth itself was quite sufficient to rivet the attention of any thinking audience, when presented without oratorical ornamentation. The other side simply rested upon the stronger argument of facts, and had but to apply the *argumentum ad hominam* in asking their opponents if they never felt the leaden weight of their eyelids grow weightier during a sermon in which there was neither gesticulation nor eloquence. Of course, the latter side won; but in regard to the delivery of medical lectures, arguments similar to those of the former debaters are continually being advanced and most strenuously, we

fear, by those who are defective themselves in the art of graceful speaking.

Eloquence of the best sort consists of the use of plain and refined language, impressive and pleasing modulations of the voice, the employment of apt and terse illustrations, and the use of appropriate gesticulations harmonizing with the thoughts expressed. Mere florid imagery and hyperbole of speech is but a debased form of oratory and the refuge of ambitious weaklings. It has no place either upon the public platform or in the halls of science.

Undoubtedly, the best means of imparting simple knowledge is the laboratory and the work-room, but since the didactic lecture still remains, and for certain reasons is likely to remain a part at least of collegiate methods of teaching, it should be made more beneficial by the use of style in its presentation. Many of our finest instructors upon medical subjects have been those who would say what they had to impart in a way that fixed the attention of every student. However dull or indifferent the latter might be, the charm and force of the speaker's manner compelled him to listen and to receive the knowledge being offered. What a treat it is to listen to a man who, perfectly acquainted with and enthusiastic about the subject of his lecture, makes it glow and burn into the minds of his hearers by reason of his well-chosen words, impassioned manner, and clear illustrations. We are positive that much of the opprobrium that has been cast upon the didactic lecture as a mode of teaching has been caused by the stale, sleepy, halting, and indifferent way that most of them are delivered. A man may be a master in the laboratory and a mere dead weight in the lecture-room, his aptitude should place him where he belongs for the best interests of medical teaching. Unfamiliarity with the subject is not unfrequently the cause of bad lectures, for,

Ce que l'on conçoit bien s'enonce clairement,
Et les mots pour le dire arrivent aisément.

In commenting upon a recent editorial upon this same question in the *New York Medical Record*, Dr. Roberts even goes so far as to say that no student ought to be compelled to attend lectures of this stupid sort, particularly when they are simply the reading of that which might be quite as well obtained from any ordinary text-book. He thinks if such a leniency were granted the student, it would act as a wholesome stimulant to lecturers for the improvement of their powers of delivery.

As the best means of teaching scientific subjects, we only favor the didactic lecture in a certain few particulars, as, for instance, when they are to be illustrated by experiments before large classes, and when they contain particularly original ideas, the result of individual experience and study. But we do maintain that among medical teachers there is a positive need of more eloquence, or rather, graceful style of speaking. What a noble opportunity is afforded for it, in the picturing of disease, in portraying the

various symptoms, in illustrating the effects of drugs, in developing the history of maladies and epidemics, in exhibiting by cumulative arguments the attainment of certain great medical facts, in demonstrating the wonders of the human body, in showing its marvellous activities in life, and in impressing the dangers and advantages of surgery? Some of the dullest subjects in the medical curriculum have been made the most attractive, some of the minutest details have been raised to their merited importance, and some of the most difficult problems have been rendered the easiest, by the employment of so simple a means as a better style of delivery in the lecture. Above all, the scientific lecturers should take heed of the advice of Horace when he says:

Quidquid præcipes, esto brevis, ut cito dicta
Percipient animi dociles, teneantque fideles.

Brevity and eloquence will make any lecture, however dull the subject of it may be, a thing to be enjoyed, and consequently to be remembered.

CO-EDUCATION IN MEDICINE.

THE announcement was made last week that the University of Pennsylvania contemplated throwing open her classes for the admission of women. No exceptions were mentioned, and the wording of the resolution, which was passed by the Faculty with but two dissenting votes, warrants the inference that the school of medicine was included.

As to the other departments, the action is only to be blamed on account of its lateness. The University cannot claim the honor of the pioneer in this matter, as many reputable schools have for years admitted women to their privileges, and the ability of the fair sex to cope with the male students, in the college classes and in the subsequent battle of life, has been fully demonstrated. With every movement looking towards the emancipation of woman, and giving her the opportunity to fit herself for any position she has the ambition to aim for, we have the heartiest sympathy. If she wishes to be a designer, an artist, an engineer, or a doctor, then, in the name of that liberty for which our fathers fought, throw open to her the doors of the schools, and allow her every opportunity and privilege which the male student enjoys.

In many respects, also, we approve of the system of co-education of the sexes. The advantages to both have been so fully discussed that we need only stop to allude to them here. Competition is stimulated and courtesy developed by the presence of both sexes in the same class. The sentiment of those who have taught mixed classes is practically unanimous in its favor. In fact, so many schools have admitted women to their classes, that it is doubtful whether the action of the University is most notable as an advance in the matter of female emancipation, or as an illustration of Philadelphia conservatism.

In the department of medicine, it appears to us

that the women have come to stay. They have surmounted every obstacle, overcome the most deeply rooted prejudice, and their success in the field of practice has demonstrated their fitness. The work of Mary Putnam Jacobi is alone a full justification of the claim of women to enter the medical profession.

But in this study we cannot approve of co-education. We cannot but believe that this would tend to weaken the barriers of delicacy, and create a degree of familiarity which is not conducive to morality. Men are men, women are women, and the fact that both are engaged in the high and noble study of the art of healing by no means frees them from the instincts of their animal nature. The study of the problems of physiology and pathology might possess too vivid an interest under such circumstances. Nor is there any necessity for such co-education. We have in Philadelphia a well equipped school for women, which affords all requisite facilities for the study of medicine; and if any further opportunities were needed, it should be by the opening of another school for women rather than admitting them to the classes with men. The impulses which would lead the students of either sex to prefer to enter a school with mixed classes are precisely those which would render such association most objectionable.

Annotations.

ACCORDING to Merck's *Bulletin*, amylen hydrate, an excellent hypnotic, is devoid of accessory or subsequent symptoms, when it is of a very high degree of purity. Having a formula $C_5H_{12}O$, it is a very mobile, colorless liquid, of specific gravity 0.81, and boiling point 100° C. (212° F.). It is soluble, *when pure*, in eight parts of water, and may be mixed with alcohol in all proportions. It has an ethereocamphoraceous taste, followed with a peppermint-like after-sensation. After an extensive experimentation, von Mering (*Therapeutische Monatshefte*, July) gives as its physiological action a perfect hypnotic effect, resembling natural sleep, without any alteration of the heart-frequency and blood-pressure. In medium doses it affects principally the cerebrum; in excessive doses it acts upon the spinal cord and medulla, and causes a disappearance of the reflex actions, cessation of respiration and an arrest of the heart. It is principally used in cases of nervous wakefulness, and occupies a place intermediate between chloral hydrate and paraldehyde. It is best administered by mouth or by rectum. The following is the most recent formula recommended by von Mering for its administration:

R.—Amylene hydrate 2vss.
Orange-flower water 3j. 3v.
Syrup of bitter orange-peel 3j.
Take one-half at bed-time.

An easy mode of giving it is to stir a teaspoonful of simple amylen hydrate with a wineglassful of beer for several minutes; then drink the mixture, and follow it by a mouthful of beer alone. Sometimes

sugar may be added. Capsules containing 15 grains may be followed by a mouthful of water, beer, or wine each. Congestion, headaches, nausea, and vomitings, are liable to be engendered by impure brands of the drug.

IN a paper on the Non-Retention of Urine by Young Girls and Women, by H. Marion Sims, in the *American Journal of Obstetrics*, for September, 1889, this troublesome condition is attributed to the contraction of the walls of the bladder due to the hypertrophy of the muscular coat and the consequent loss of its holding capacity.

He has treated a number of cases in both children and adults, and has had the satisfaction of curing all but two of the cases completely, with no other aid than forcible dilatation by warm water. This was done by using an ordinary silver catheter, to which was attached a Davidson syringe. The quantity of water injected was measured by knowing that the bulb of the syringe, when completely emptied, threw into the bladder exactly one ounce of water. The water used was just comfortably warm. In one of these cases the bladder would hold at the first time but one and three quarter ounces, and the quantity was increased gradually each day, until it would hold eighteen ounces of water, and that without severe pain. The treatment lasted three months.

BY means of our ready facilities for research, we are enabled to call attention to an oversight, and credit the proper authorities with the method for collecting bacteria and other microorganisms in drinking water, for biological examination and analysis, described on page 695 of the September number of the *University Medical Magazine*. The use of sterilized asbestos in glass tubes, as there suggested by Prof. Dixon, was recommended some three years ago by Petri, chief-assistant to Prof. Koch in Berlin, with a full account of the same in the *Zeitschrift Für Hygiene*. The method has been employed ever since in the regular examination of the water supplied to the city of Berlin.

Letters to the Editor.

ANTIFEBRIN.

IN reply to Dr. Saylor on "antifebrin" in your issue of September 7, I would say that a temperature of 102 to 103 in a child, is not of sufficient magnitude to cause much anxiety, nor would it be even in an adult; though I can see no fault in an administration of antipyretics to a moderate degree. The Doctor states that authorities claim that the effect of the drug lasts six hours, and asks if I would not commit the same error as Dr. Penny, if I repeated the dose every three or four hours. I think I stated that I repeated the dose every three or four hours until I got the desired effects, and, inasmuch as the drug manifests its effects in from thirty to sixty minutes, there would hardly be any danger in giving the drug as I suggested.

R. H. ENDICOTT, M.D.

OAKDALE, Cal.

SUPPOSED NEURALGIA.

MR. H—, age twenty-three, who had been suffering from neuralgia on the left side of the face, for the last two years, called on me for treatment, and gave the following history: Two years ago in July, he had been troubled with an abscessed tooth, and had the same extracted; the pain had ceased for about a week, but came on again, and he has had it since, periodically, it being more severe in damp weather, but never leaving him for more than a few days at a time. He had taken all kinds of drugs, but did not get much relief from them, and finally called on me, suggesting that he thought the pain was caused by a wisdom tooth next to the space of the extracted molar. I examined the same and found it, as well as the surrounding tissue, in a healthy condition. That it might be a lesion of the floor of the antrum next suggested itself to me; I therefore opened up the gum freely and immediately upon my doing so the pus began to flow; I cleaned it out thoroughly, and upon probing into the cavity, I struck a hard substance, which upon removal proved to be one of the roots of the extracted abscessed tooth. It was lying horizontally in the gum and was pressing against the floor of the antrum. After removing the root and pus from the cavity, I thoroughly antisepitized it. It healed very nicely, and the patient has been free from pain ever since. As a local anesthetic in this operation I used:

R.—Olei cinnamomi 3j.
Olei gaultheriae 3ij.
Acidi carbolici 3ij.

M.—Applied until the part turns white.

I have used the same in tooth extractions and other minor operations with general success.

DR. W. U. ROSENTHAL.

CHICAGO, ILL.

DOUBLE AMPUTATION OF THE FEET.

THE patient, forty-four years old, a man of dissipated habits, had been guilty of a misdemeanor and in order to evade arrest, had slept out of doors in a straw stack during a very cold night, freezing all of his toes as well as the contiguous parts of his feet so severely as to require amputation. When I first saw him his toes were black, dry, and could have been disarticulated by slight torsion. Immediately above the metatarso-phalangeal articulations of both feet a line of demarcation was quite apparent with a very free and offensive discharge of pus, coming mostly from the joints. After putting the patient under the influence of an anesthetic, I amputated one foot through the tarsus so as to remove the navicular and cuboid bones with all of the parts in front, according to Chopart's method, procuring a good flap from the sole of the foot. Dr. C. McCracken, of this place, who was assisting, amputated the other in the same way with same results. By the time the stumps were dressed, the patient had rallied from the anesthetic and shock without any of the unpleasant effects which often follow operations. Local treatment consisted of sol. hyd. corros. 1 to

1000 used as a spray at each dressing. As an ointment for dressing:

R.—Cerati resinæ,
Copaibæ partes equales
Fiat unguentum.
Sig. To be used pro re nata.

The stumps healed rapidly, and in a few weeks the patient was able to be around on crutches and shortly after went to work, his trade being that of a cooper. When I last heard from him, one year after the operation, he could walk very well, and his lameness did not prevent him from doing a full day's work.

T. G. STEPHENS, M.D.

SIDNEY, IOWA.

Society Notes.

ALLEGHENY COUNTY MEDICAL SOCIETY.

Special Meeting, August 20th, 1889.

JAMES McCANN, M.D., IN THE CHAIR.

TREATMENT OF PULMONARY PHthisis.

DR. LANGE reported a new method for the treatment of pulmonary phthisis. "The method consists in the inhalation of vaporized mercury and iodine. Of the results of this method I have nothing to say. I cannot forget that grass has not yet grown upon the grave of gaseous enemata, and I am aware that many men, many years and many cases, are required to produce evidence of the usefulness of any remedy or method in the treatment of anything, even when the remedy or method possesses usefulness. I report this method because I desire co-workers.

It suggested itself to me that vaporized mercury, if brought into more or less direct contact with the bacillus of Koch, might destroy it, and that iodine, if applied directly to the ulcerating surfaces of lung tissue might effect a more powerful beneficial action than that resulting from its ordinary method of administration. I have had, and still have, the valuable assistance of Dr. Tingley in the preparation of apparatus and in devising ways and means by which these vapors may be satisfactorily administered to patients. This has presented many difficulties. A principal one is, that I know of no manner, as yet, by which a definite, a known quantity, can be given. The vaporized mercury salts are resublimed and deposited upon the cooler parts of the apparatus. This is particularly true of the inhaling tube, which is always the coolest part of the apparatus. The consequence of this is that patients receive always an unmeasured, an accidental quantity, of these salts or vapors, and not a quantity which is measured or known. To this fact are due two accidents, namely, that one very feeble patient was violently purged, and another was salivated. However, we hope to overcome this defect of apparatus and to be able soon to give patients exact quantities of these salts. The desideratum is an inhaling tube which will bear the temperature necessary to hold the mercury salts vaporized up to the lips of the patient, and which at the same time shall be flexible. Flexibility is almost a necessity; a feeble patient cannot breathe deeply

and persistently from a stiff tube, a glass tube, such as I now use.

I have found that the only salts of mercury available for this purpose are the red oxide and calomel. All others are reduced before being volatilized. I began with the iodide of mercury. This and all others when used result in the vapor of metallic mercury only. I have found no objection, however, to the use of metallic mercury, only it is to be noted that when other salts than calomel and the red oxide are used, the patient receives the vapor of metallic mercury.

Can the vapor of mercury, or can anything inhaled, reach the bacilli in a tuberculous lung? Those bacilli which are in consolidations, provided such a consolidation is connected with a pervious bronchial tube, those in lung cavities furnished in the same manner, those in the bronchial tubes, those in the alveoli, and those in the sputum may be reached by this vapor, or by anything which may be deeply and persistently inhaled. But these bacilli are comparatively inert; they are harmless; they have already accomplished their mission of destruction, and are being extruded from the body. Those whose destruction is very much more desirable, those which have not yet, but which certainly will, produce consolidation and softening, *i. e.*, destruction of lung tissue, those in the pulmonary connective tissue, and the lymphatic sheaths of the bloodvessels, can these be reached by anything that may be inhaled? Again, if we grant that in a certain patient every bacillus has been destroyed, this is by no means synonymous with his cure. Evidences of this fact are presented daily; patients die of non-tuberculous phthisis very readily. And the tuberculous patient with every bacillus in his lungs destroyed, possesses still that fatal predisposition, and will be reinfected.

It is a question also whether mercurial vapor is a germicide. No one will deny this property to corrosive sublimate. But corrosive sublimate is not volatilizable, and volatilized mercury, volatilized calomel, and red oxide, are very different substances indeed.

Despite these theoretical objections I am encouraged to proceed with this treatment of phthisis, and when I have perfected the apparatus, and have a series of cases certainly tubercular, as demonstrated by the discovery in the sputum of the bacilli, which Dr. Matson has kindly consented to do for me, I shall report again to the Society."

DR. R. W. STEWART exhibited his

IMPROVED URETHRAPH,

and announced that it was now as nearly perfect as he could make it, and that he had made arrangements by which the profession could be supplied. As at present constructed the instrument can be introduced within the bladder, and by merely withdrawing it, it will give a tracing of the entire length of the urethra. He exhibited tracings taken from a single patient under the care of Dr. Carrington, the first before operation, and the second after operation with Holt's divulsor. The result of the operation was evident on the tracings.

DR. J. D. THOMAS complimented Dr. Stewart on

the construction of the instrument, and stated that he had long since recognized the defects in Dr. Otis' urethrometer; it was too stiff; the distal side as well as the distal portion of the stricture was easily enough detected and measured, but as the "meter" was brought forward the variations in the caliber and the proximal termination of the stricture required very delicate manipulation and much experience, to gain the desired information. In this connection Dr. Thomas exhibited to the Society an improved urethrotome of his own invention. In his experience the Otis urethrotome had three defects:

1. After the blade was drawn forward and the stricture divided it was necessary to push the blade back into its sheath or recess and thus, although not intentional, make two incisions—the second one likely to be a lacerated one.

2. If more than one stricture existed the instrument had to be adjusted for each stricture, thus causing unnecessary irritation of the urethra, and

3. As the instrument opened on the principle of a parallel ruler, there was more or less displacement after the instrument was opened. Dr. Thomas demonstrated the working of his urethrotome and showed that by its use the above objections were overcome. The instrument of Dr. Thomas is made by Tiemann & Co., of New York.

DR. WERDER read a paper reporting a case of

FIBRO-CYSTIC TUMOR OF THE UTERUS.

(See page 558).

DR. J. J. BUCHANAN: This operation, at which I was present, was a very difficult and interesting one. From the appearance of the patient prior to operation, I do not believe that it would have been possible for anyone to have made a diagnosis other than ovarian cystoma. The fluctuation was as distinct as though the tumor had been a single sac filled with fluid. The tumor was markedly at one side of the abdomen. It lay in front of the uterus, and in every respect that I can now think of, it exactly imitated the behavior of an ordinary ovarian cyst. With regard to the pathology, I think it rather unfortunate that there was no microscopical examination made. As to the treatment, I think it was everything that could be desired, as the result proved, although I believe that a large proportion of these cases when so treated are fatal on account of the extensive amount of tissue which has to be left to slough in the neighborhood of the peritoneal cavity. The suggestion of Dr. Werder that probably the enlargement of this growth midway between the menstrual periods was coincident with the period of ovulation, I think is hardly susceptible of proof.

DR. BLUME: Doctor Werder is to be congratulated for his successful operation. His case offers some interesting points as regards diagnosis and treatment. All authorities tell us, that an exact diagnosis in cases of large abdominal tumors often is impossible, and every one who has had an opportunity to examine such cases will confirm this. I desire to call your attention to a diagnostic symptom which has not yet been mentioned in our textbooks. Recent investigations by competent men have proven,

that in all cases of uterine tumors the endometrium is diseased. Clinical experience has taught this long ago. Hemorrhage in form of menorrhagia or metrorrhagia is known to be often a prominent symptom of fibroma and myoma. The endometritis in these cases is usually the consequence of the growth and therefore secondary. In diseases of the ovaries—oophoritis and cystic ovaries, as well as in tubal diseases, endometritis is constantly met with, and here often as a primary malady. Malignant growths of the ovaries, sarcoma and carcinoma, are also complicated with a diseased endometrium, while this complication is seldom found in cases of ovarian cystoma.

Although there are patients with large fibroma or myoma, who never lose an excessive amount of blood, and the case under discussion is an example, endometritis nevertheless always exists as a complication.

I therefore suggest, that in all cases of large abdominal tumors, after all diagnostic means to arrive at an exact diagnosis are tried in vain, the endometrium should carefully be examined. If endometritis is found to be present, the tumor may originate from the uterus. If the endometrium is found to be healthy, the tumor is proven not to be in connection with the uterus.

The treatment resorted to in this case appears to be somewhat different from the usual modus operandi. The tumor, if I understood the doctor right, was a myoma interstitialis, developing from the fundus and the right uterine wall. The ligaments were tied, the tumor cut away, and a large pedicle treated extra-peritoneally. Tumors of this kind are either enucleated and the uterine walls stitched together, or removed by supra-vaginal amputation, the pedicle treated either intra—or extra-peritoneally. The extra-peritoneal method, strongly advocated by Hegar and Kaltenbach, has given the best results. Kaltenbach lost 1 of 22 cases, equal to to 4½ per cent., Keith 2 of 38, equal to 5¼ per cent. I am in doubt, like Doctor Buchanan, whether or not it is indifferent to form a thick pedicle, as was done in this case.

A few months ago I saw a similar operation performed by Dr. Burns. The tumor, a large fibroma, broadly attached to the fundus uteri was not enucleated, but removed by a wedge-shaped incision. The remaining portion was carefully sewed, and the patient made a rapid recovery.

NEW YORK STATE MEDICAL SOCIETY.

(Concluded from page 545.)

THE second day opened as follows:

Address on Surgery (read by title), by Francis Bacon, of Connecticut.

Alcoholic Paralysis, by T. D. Crothers, of Hartford, Ct.

A Few Fads, by H. N. Didama, of Onondaga Co. Some of the Uses of the Transfixion Ligature, by T. H. Manley, of New York Co.

The Shadow-line of Insanity, by John Shrady, of New York Co.

Then came the interesting discussion on the "Treatment of Hernia," in which the writers were Joseph

D. Bryant, William T. Bull, Charles W. Brown, T. H. Squire, Wm. S. Tremaine, Roswell Park, Charles McBurney, Charles L. Squire, D. M. Totman, Frederick S. Dennis, and John A. Wyeth, all of New York State. The points of the debate related to the special mechanical treatment, the injection, open and non-open methods, the technique and the plan of procedure when gangrene of the sac or its contents becomes a complication.

"The Lantern Views" of Edward K. Dunham, of New York City, showing the details, methods and technique of microbial culture, awakened considerable enthusiasm. A collation which pleasantly accentuated the fellowship of the occasion, encroached somewhat upon the sleeping hours.

On the third and last day the "Address on Medicine," entitled the "Bacteriological Test of Drinking-Water," was delivered by Edward K. Dunham, of New York Co., and further elaborated his efforts of the previous night. The other papers were:

"The Cure of Haemorrhoids by Excision, and Closure with the Buried Animal Suture," by Henry O. Marcy, of Massachusetts. An especially commendable one.

"Report of a Case of Ataxic Paraplegia," by Darwin Colvin, of Wayne Co.

"Observations on Dislocations of the Hip," by U. C. Lynde, of Erie Co.

The discussion on the "New Hypnotics," *e. g.*, Sulphonal, Amyl Hydrate, Hydrobromate of Hyoscine, Hypnone, Paraldehyde and Urethan then followed. The participants were William H. Flint, Austin Flint, E. G. Janeway, Charles Rice (Ph.D.), Charles G. Stockton, John G. Truax and Edward R. Squibb, all of New York State. These contributions are worthy of a very wide circulation among the profession. Then followed: "Extraction of Cataract without Iridectomy," by Charles Stedman Bull, of New York Co.; and "Two Cases of Angular Deformity of the Knee Joint," by Lewis Hall Sayre, of New York Co., in which the compensatory results of amputation with the view of wearing an artificial leg were admirably shown in the person of a patient who wore his substitute for the first time at this session.

The following nominations were announced and unanimously elected: John G. Orton, of Binghamton, President; Douglas Ayres, of Montgomery County, W. H. Burton, of Troy, E. Mott Moore, Jr., of Monroe County, William B. Eager, of Orange County, Vice-Presidents; John H. Hinton, of New York, Treasurer; E. D. Ferguson, of Troy, Secretary; John W. S. Gouley, Director of Library. First District, C. M. Klock and W. H. Biggam, of Montgomery County; Second District, Thomas Wilson, of Columbia County; Third District, H. O. Jewett, of Cortlandt County; Fourth District, Simeon T. Clark, of Niagara County; Fifth District, John J. Truax, of New York, as members of the Council. The meeting then adjourned. By way of finale, we may say that this association has a glowing future before it.

PROF. TYSON gave the introductory lecture at the University of Pennsylvania.

Book Reviews.

WOOD'S MEDICAL AND SURGICAL MONOGRAPHS. Volume III, No. 2, August, 1889. Containing: The Treatment of Syphilis at the Present Time, by DR. MAXIMILIAN VON ZEISSL; The Treatment of Inebriety in the Higher and Educated Classes, by JAMES STEWART, B. A.; and Manual of Hypodermic Medication, by DRs. BOURNEVILLE and BRICON. Price \$1.00. Pp. 544. William Wood & Co., New York, 1889.

The first of the above monographs is an admirably prepared exposition of the more highly endorsed methods of treating syphilis at the present day. Though positive in his own views, and relying largely upon his own wide experience, the author has, nevertheless, carefully and impartially represented the opposing opinions upon this much-vexed question. He is a firm believer in the unicist theory of the disease, holding that the primary lesion is merely the local expression of a general infection. Hence he insists upon the uselessness of excision with or without implication of the neighboring glands. In certain cases the primary soil may be cut out, simply to remove a source of auto-infection, and so avoid unnecessary prolongation of the constitutional treatment. Likewise is he opposed to the preventive methods of treatment, either by injections into the glandular regions before their implication, or by the administration of the erroneously called antisyphilitics or antidotes to syphilis. Statistics have not established their efficacy. They simply act in this disease somewhat as they do in cadaveric or gonorrhœal poison, to place the organism in a position to wage a more successful struggle. He favors the milder methods of treatment, save in exceptional cases, and recommends the continuation of the treatment as with iodine, for at least six months or a year after the disappearance of the special symptoms. In regard to Neisser's plan of deep injections of calomel, he expresses a favorable opinion, though as yet a guarded one, in the absence of a more extensive experience with it. We commend Dr. von Zeissl's brochure to the careful consideration of those who wish to be acquainted with the views of a fearless and impartial specialist in this department of medicine.

Mr. Stewart's is a short paper, strenuously endorsing the treatment of inebriates in the homes of rural practitioners, where they may be entirely separated from relatives, sympathising friends and customary influences, and be under the constant supervision of a kind but strict supervision. Inebriety is a positive disease, and must not be confounded with mere drunkenness. Its treatment with drugs, such as capsicum, bark, etc., amounts to little more than a farce. The author recommends the complete withdrawal of the stimulus, and declares that it is perfectly safe, when the patient is constantly under the eye of a medical man. The paper is full of excellent suggestions in regard to the general management and dieting in inebriety, and, being written by one who has had a large experience in this field, will be read with special interest by the profession.

The Manual of Hypodermic Medication occupies about three-fourths of the volume. It is a translation of the second edition of this justly popular work

among our foreign confrères. Among the new preparations, not to be found in the first edition, are chrysarobin, osmic acid, agaricin, antipyrine, convallaria maialis, eucalyptol, ichthyol, kairine, phenacetine and others. After a short history of hypodermic medications, and an illustrated chapter upon the methods and instruments employed, follow the descriptions and formulæ of the principal drugs administered in this way. The text has been made more available for American practitioners by the transmutation of the metric system of weights and measures into the English. Several useful tables and indexes add materially to the practical value of the work.

THE RETROSPECT OF MEDICINE. A Half-Yearly Journal, Containing a Retrospective View of every Discovery and Practical Improvement in the Medical Sciences. Edited by JAMES BRAITHWAITE, M.D. Lond. Vol. XCIX., Jan.—June, 1889. London: Simpkin, Marshall, & Co. 444 Pp.

This old friend makes its appearance this month in a new and greatly improved form. Instead of the usual paper back book, it is now presented by the publishers in the form of a compact, neatly bound volume in cloth, an improvement which at once commends itself to the reader. The long-established reputation of the "Retrospect" needs no further enhancement or recommendation by us. Each volume as it appears takes at once its place in the highest estimation of the profession, as a valuable encyclopædia of the latest advances made in the medical sciences.

Pamphlets.

Practical Notes on Urinary Analysis. By William B. Canfield, A.M., M.D., Lecturer on Normal Histology, University of Maryland. Reprint from *Maryland Medical Journal*. Baltimore, 1887.

Retained Debris as one of the Causes of Puerperal Fever. The Intrauterine Douche and Curette. By Chas. H. Earle, M.D., Chicago.

Suicide and Legislation. By Clark Bell, Esq., President of the Medico-Legal Society of New York. Reprint from the *Medico-Legal Journal*, June, 1888.

The Treatment (non-preventive) of Puerperal Fever. By Chas. H. Earle, M.D., Chicago. Reprint from the *Chicago Medical Journal and Examiner*.

The Medical Digest.

NAPHTHOL-CAMPHOR is a valuable antiseptic, whose application is not followed by pain. Salol-camphor has similar properties. They are prepared by adding 200 parts of camphor to 100 parts of betanaphthol or 300 parts of salol; reduced to a fine powder and gently warmed until they liquefy. The product is filtered and preserved in a well-closed bottle. They are miscible in fixed and volatile oils, ether, and alcohol. They have some solvent power, over iodine, cocaine and the cinchona salts. They are useful for preserving instruments, as they affect neither wood nor metal.—*Pharm. Jour.*

THE DISTRIBUTION AND DURATION OF VISCERAL NEW GROWTHS. The above was the title of the Bradshawe Lecture, delivered by Norman Moore, M.D., F.R.C.P. at the Royal College of Physicians of London, recently. After a systematic review of the evolution of our knowledge of visceral growths, from Hippocrates down to the present day, and a study of some of the well-ascertained facts in regard to their structure and natural history, the lecturer proceeded to give the results obtained from the examination of one hundred and twenty-three cases of new growths in the internal organs of the body, which had come under his observation, and included one hundred and two cases of carcinomata, and twenty-one sarcomata. As a result of this series of examinations, he arrives at the following conclusions:

1. That the *œsophagus* is a common seat of new growth in men, a very rare one in women.
2. That, in carcinoma of the *œsophagus*, the new growth is rarely confined to that organ.
3. That it may grow, along with the *œsophagus*, into the stomach.
4. That it may grow directly into the lung, and that this is a frequent occurrence.
5. That it may grow directly into the mediastinal glands.
6. That it may, though rarely, infiltrate the dorsal vertebrae.
7. That it is frequently associated with widespread secondary growths, of which the commonest seat is the liver, and that, after the liver, the lungs, heart, and kidneys are more often affected than any other viscera.
8. That the *stomach* is a common seat of new growth in both sexes.
9. That carcinoma of the stomach generally grows from the pylorus towards the cardiac end of the cavity.
10. That the growth is rarely continued into the *œsophagus*, but more often than into the duodenum.
11. That, in about one-fourth of the cases, the growth extends directly into the lymphatics, along one or both curvatures of the stomach, forming dense masses, which may often be felt through the abdominal wall.
12. That, after these lymphatics, its most frequent seat of growth in continuity is the liver.
13. That it may also grow in continuity, though with less frequency than into the liver, into the diaphragm, omentum and mesentery, pancreas and transverse colon, and less often still into the ascending colon, spleen, vertebral column, and vena cava inferior.
14. That in two-thirds of the cases there are secondary growths, and that in one-third these are widespread, affecting one or more regions.
15. That the commonest seat of secondary growth is the liver, and next to it remote lymphatics, especially the glands in the hilum of the liver, the lumbar and mesenteric glands, and those of the mediastinum.
16. That after these the pancreas and lungs are most often the seat of secondary growth, and with nearly equal frequency.
17. That secondary growths are rare, but may also occur (in the order of frequency) in the peritoneum generally, and in the kidney, and least often and with equal rarity, in the heart, spleen, and supra-renal bodies.
18. That carcinoma of the *colon* tends to spread, by direct continuity, and may thus, according to its situation, penetrate the stomach, duodenum, ilium, or abdominal wall.
19. That it rarely has secondary growths, and that when these occur they are commonest in neighboring lymphatics, and may rarely be found in the liver.
20. That, in carcinoma of the *rectum*, a majority of the cases have neither growth in continuity nor secondary growths.
21. That the lumbar glands and the liver are the most frequent regions of secondary growth when occurring.
22. That the pancreas is sometimes infiltrated.
23. That the stomach is a more frequent seat of new growth than the *œsophagus*, and the *œsophagus* than the *colon*, and that, notwithstanding its greater length and therefore greater area of epithelium, the small intestine is the least frequent of all.
24. That new growths of the *œsophagus* lead to most widespread secondary growths, and new growths of the *colon* to the least widespread.
25. That new growths of the *colon* have the greatest tendency, perhaps owing to their situation, to grow directly into the other parts of the alimentary canal.
26. That carcinoma of the *gall bladder*, and *large bile duct* (generally the common duct) usually grows directly into the liver.
27. That secondary deposits, if present, are not widespread.
28. That their most frequent seat is the abdominal lymphatics, but that they may occur, in order of frequency, in the lungs, the liver, and the peritoneum.
29. That the *liver* is a rare seat of primary new growth.
30. That primary new growth in the *pancreas* occurs in both sexes.
31. That, in carcinoma of the *pancreas*, growth in continuity is rare, but may take place into the stomach, gall-bladder, transverse colon, or duodenum.
32. That secondary growths are not usually widespread, and that their commonest seat is the liver.
33. That they may also occur in the lungs, kidney, peritoneum, and heart.
34. That primary new growth in the *lungs* may be a carcinoma or a sarcoma.
35. That endothelioma of the *pericardium* may grow directly into the lung.
36. That its secondary deposits are usually widespread, and may include the liver, pancreas, spleen, kidney, and supra-renal body.—*Medical Press and Circular*, September 4.

GLYCERIN reduces the causticity of carbolic acid, provided no water is present. In cases of burns by this acid the skin should be washed with alcohol or pure water-free glycerin.

IN a paper published in the *Bul. Gen. de Ther.* upon secondary post-partum hemorrhage M. Misrachi arrives at the following conclusions :

1. Secondary post-partum hemorrhage is an accident always alarming, often dangerous, and important to be stopped with the least possible delay.
2. Intra-uterine injections, which are an enormous improvement over former methods of treatment, are not always efficacious, and often require considerable time before effecting a cure.
3. The antiseptic dressing of the uterus by means of a species of curette or some other convenient instrument, is a method of treatment as inoffensive and much more rapid and effectual than intra-uterine injections.

TREATMENT OF DIPHTHERIA.—M. Gaucher employs the following formula :

R.—Camphor 20 grammes.
Castor oil 15 grammes.
Alcohol at 90° 10 grammes.
Phenic acid (crys.) 5 grammes.
Tartaric acid 1 gramme.
M.—Sig. Apply locally.

—*La Tribune Médicale.*

IODOFORM IN CYSTITIS.—

R.—Iodoform 50 gr.
Glycerine 40 gr.
Distilled water 10 gr.
Tragacanth 25 gr.
M.—D. S. Add a spoonful of this emulsion to one-half liter of warm water and shake thoroughly.

The injections should be repeated every three days until four have been given, when once a week will suffice.—*L. Frey, Revue de Ther.*

AN ABORTIVE TREATMENT OF CARBUNCLE BY IODOFORM.—This treatment consists in :

1. Disinfecting the diseased part with a carbolic solution of 1 part to 40, or with a solution of 1 part in 2000 of sublimate.
2. Spreading upon the surface a layer of powder prepared as follows :

R.—Fine powdered Iodoform,
Oxide of Zinc equal parts.

M.—S. A.

This dressing should be made with a brush dipped in phenic oil, and repeated twice daily and continued until the complete drying up of the tumor.

IN a report read by M. René Lavalle at the Academy of Political and Moral Sciences, was the following :

At Reichenberg in Bohemia 6 per cent. only of the recruits were found good for the service, and of 365 weavers, not more than 9 per cent. At Berlin in 1000 recruits scarcely 40 were fit for service. War and manufacturing work—these are the two factors in the degeneration of the race; war because it destroys the strongest and best constituted men; industry because it atrophies them. The people to whom the future belongs are the agriculturalists.—*Revue de Ther.*

THE TREATMENT OF PLACENTA PRÆVIA.—In a paper read before the Obstetric Section of the British Medical Association at Leeds, in August, Dr. J. Braxton Hicks advances the following rules which should be observed by obstetricians when dealing with that dangerous complication of pregnancy, *placenta prævia* :

1. After diagnosis of *placenta prævia* is made, proceed as early as possible to terminate pregnancy.
2. When once we have commenced to act, we are to remain by our patient.
3. If the os be fully expanded and the placenta marginal, we rupture the membranes and wait to see if the head is soon pushed by the pains into the os.
4. If there be any slowness or hesitation in this respect, then employ forceps or version.
5. If the os be small and placenta more or less over it, the placenta is to be carefully detached from round the os; if no further bleeding occur we may elect to wait an hour or two, but should the os not expand, and if dilating bags are at hand, the os may be dilated. If it appears the forceps can be admitted easily, they may be used, but if not, version by combined external and internal method should be employed, and the os plugged by the leg or breech of the fetus; after this is done, the case may be left to nature, with gentle assistance, as in footling and breech cases.

6. If the os be small, and if we have neither forceps nor dilating bags, then combined version should be resorted to, leaving the rest to nature, gently assisted.

7. If during any of the above manœuvres sharp bleeding should come, it is best to turn by combined method in order to plug by breech.

8. Where the death of the fetus occurs before the end of the seventh month, version by combined method, no force following, is the best plan.

The after treatment must be conducted on the modern principles. Should oozing occur after the expulsion of the placenta, the swabbing of the lower uterus by styptics will be easy, and inasmuch as the outlet of the uterus is liable more especially to be blocked by adherent clots, it will be wise to irrigate the uterus daily with some antiseptic solution, or insert iodoform pessaries in the vagina, particularly if the irrigation cannot be done.

—*Medical Press and Circular.*

FOR ACNE.—Gailleton has employed with success the following pomade :

R.—Iodochloride of mercury gr. ivss.
Ung. simp $\frac{3}{5}$ j.
M.—S. Apply with prolonged frictions. The reaction is very energetic.

—*Revue de Ther.*

FOR INFANTILE ECZEMA.—

R.—Acid boric gr. lxxxj.
Vaselini $\frac{3}{5}$ j.
Bals. Peruan gr. vijss.
M.—S. Apply to the parts affected.

—*Delapert, Revue de Ther.*

HINTS IN URINARY DISEASE.—Ultzman's work on "Urinary Disease" contains a number of excellent suggestions which, without being novel, present the treatment of some more common forms in a concise modern light. *Urethritis anterior gonorrhoeica* is due to invasion of Neisser's gonococci and has a typical course, beginning at the external orifice, and gradually invading backward, until, in the fourth week, the bulbous urethra is attacked, and thus, in some cases, the case terminates. The treatment required is really, besides careful diet and rest, only cleansing of the canal with a gently astringent injection of alum, zinc or potass permanganate. The object is to render the cyclical course of disease free from complication. Meat should be avoided, except white meat; stimulants, coffee and spices, to be avoided. A suspensory bandage should be used. In active inflammation, cold compresses and injections of three per cent. boric acid solution; later a solution of alum, sulph. zinc and carbolic acid, about one grain each to the ounce, urinating three to six times daily. This solution is to be increased in strength as the tenderness ceases. Chronic gonorrhoea Ultzman treats by sounds, splitting of external meatus if necessary, by deep irrigation through a catheter, or by bougies of tannin and zinc with cocoa butter.

For treatment of strictures Ultzman advises either temporary or permanent dilatation, with the following rules:

1. Only new, perfectly disinfected sounds or bougies should be used.
2. Always begin with a number which on the previous day passed easily, then use the larger ones.
3. When a catheter can be introduced, it is useful to irrigate the canal for disinfection after each dilatation.
4. If bleeding occurs, all attempts should cease, order patient to be quiet, refrain from urinating several hours, and apply cold compresses to the perineum.
5. No sound should be introduced without previous examination of the fresh urine. If albumen is found present or increased, it is safer to defer treatment.

In very narrow strictures, Dunreicher's method is to be commended, viz.: to introduce a number of filiform bougies in succession, retaining all until one passes.

Elastic bougies should lie ten minutes; From No. 1., English, a stricture should be dilated to fifteen with bougies; then sounds up to twenty-four should be used. Now patient may introduce lead-rubber bougies, before retiring to bed, allowing them to remain one-quarter to one-half hour, first daily, later twice a week. Permanent, slow dilation is executed by allowing the instrument to remain twelve hours, the urine being evacuated alongside the bougie. Each day two numbers may be advanced, taking care to retain a size which passes easily. In this manner Ultzman claims to dilate strictures in four to five days without danger.

In retention due to stricture he recommends warm applications, baths and narcotics, followed by injections of a few drachms of oil, which is gently forced

back by stroking. The penis is now firmly drawn forward, and a filiform bougie is introduced and retained ten minutes. The patient now rises and is ordered to pass urine, while the bougie is being withdrawn slowly. This process is repeated several times until the bladder is emptied. He regards this method as "excellent and always to be applied."

Ultzman regards internal urethrotomy as not to be preferred to dilatation in results. External urethrotomy cannot be dispensed with in some cases.

VAGINAL MYOMECTION.

Vaginal enucleation of uterine fibroids has gone out of vogue, since laparotomy has become so fashionable. Chrobak (*Med. Jahrbuecher*, ix, 535) regards enucleation as more in accordance with modern conservative surgery than laparotomy.

As a first condition all operators demand a short, wide, soft cervix; a narrow, long rigid one is a contraindicator. This may be correct when very large tumors are involved. But he advises enucleation in ordinary sized tumors, whenever it seems feasible to deliver them without great force. For this purpose a capacity for dilatation of the cervix suffices, and in one case (13) an absolutely virgin uterus did not prevent the enucleation of an egg-shaped growth 6 by 4.5 cm. diameter. He begins dilatation by tupelo tents; when the cervix is almost dilated, he increases the opening by making with scissors five or six radiating incisions, which are stitched after the operation. The best time for operation is immediately after the menstrual period. Submucous fibroids are the most suitable, but he has enucleated two multiple subserous tumors. Instruments should be avoided as the fingers must do most of the work.

A speculum is rarely used; the cervix is grasped high up by hooks, and the uterus drawn down. The incision is best made across the point where the tumor clearly leaves the uterine wall; in high tumors the most accessible point is chosen. The splitting is done by a probe-pointed knife or with a curve polypus scissors; the incision being widened by the finger or dull raspary. The cautery iron is dangerous.

Enucleation should be made with the fingers, which may be aided by twisting with hooks, rarely by cutting.

Chrobak deprecates the use of violence, although a certain amount is needed. Instruments for grasping the tumor securely are, however, required. Very large tumors may be compressed by the cephalotribe or cranioclast, or they may be removed piecemeal, after applying elastic ligature. Patients' nates, vulva and vagina are rendered aseptic by irrigation and brushing with sublimate solutions, an iodoform pencil is put into the uterus, iodoform gauze tampon into the vagina, which is removed just before operation. During the latter a weak salicylic stream is played upon the parts; the hands are dipped in cold sublimate solution when they become numb. After enucleation the uterine cavity is thoroughly irrigated and swept with cotton tampons dipped into sublimate or carbolic solution. Loose remnants are not removed; they shrivel. Chrobak tampons the uterus and drains it with iodoform wicks, and gives ergotin

subcutaneously. On the fourth or fifth day the dressings are removed, unless earlier demanded by a rise of temperature. Chrobak publishes nine cases in addition to his previous eleven cases, of which one died. His communication certainly deserves attention in this day of indiscriminate laparotomies.

FOR PHthisis.—

B.—Hydrarg. biniodid	gr.xv.
Potass. iodid	gr.xv.
Aquaë dest	oij.

M.—S. For use with the atomizer.

—*Rueff, Revue de Ther.*

INCOMPATIBILITY OF ANTIPYRINE WITH OTHER DRUGS.—M. Charles has called attention to the precipitate which is formed by mixing solutions of antipyrine and cinchona, and M. Ferand has made later some experiments which warrant him in saying, that in mixtures containing antipyrine and cinchona all the active principles of the potion are precipitated and leave in the filtered liquid scarcely a perceptible trace of antipyrine and the alkaloids. He notices, as did M. Charles, that the precipitate is readily soluble in weak acids, from which he concludes that the potion does not become inert, as the precipitate should dissolve in the gastric juice.

TREATMENT OF DIPHTHERITIC CONJUNCTIVITIS.—M. Agnifor Blanch considers this disease first as a local and then a general disease, and favors the increase of the conjunctival secretion as a means of detaching and eliminating the false membrane. This treatment consists of lavings of boric acid or of sublimate 2 to 1000 solution, the detachment of the false membrane with a forceps, the cleaning of the mucus with a linen cloth dipped in lemon juice or tartaric acid, and then the application upon the conjunctiva of a substance intended to prevent the false membrane from being reproduced. This substance is Helentine, which appears to act specially upon the microbes of diphtheria, and which besides increases the vascularity of the conjunctiva and its secretion. Then it is necessary to avoid absolutely from moist heat.

—*La France Médicale.*

M. Blainville, pharmacist, records a new incompatible with antipyrine; having had occasion to mix 4 grammes of antipyrine and 5 grammes of hydrate of chloral, and 15 grammes of water, he found the mixture became milky, then clearing deposited an oleaginous liquid. Decanted, this liquid possessed neither the taste of antipyrine nor of chloral, but resembled coriander seeds.

Upon the subject of incompatibles, which are discovered each day by pharmacists, M. Ferand remarks, that they should avoid mixing substances as complex as antipyrine with chemicals capable of modifying its composition, and consequently its physiological action.

Formulas the most simple, said he, such as distilled water sweetened, should be the rule when prescribing a new body used in therapeutics before all its chemical characteristics are thoroughly studied.

—*La France Médicale.*

Medical News and Miscellany.

DR. F. D. CASTLE has removed to 1502 Walnut Street.

DR. ANDREW GRAYDON has removed to 1338 Walnut street.

PROFESSOR KEEN was too ill to give his introductory lecture.

THERE were twenty-one deaths from starvation in London last year.

FOOT-BALL playing has commenced at the University of Pennsylvania.

It has been stated that next year the University is to have a new Provost.

The outbreak of cholera in Mesopotamia is exciting apprehension in Russia.

Artificial cloves have appeared in the market. Theatre-goers, take warning!

In La Grasse, France, where perfumes are largely made, phthisis is said to be unknown. (?)

CITRON cream is a good application for cracked lips. Ung. hydrarg. ox. rub. is another.

ENGLISH medical journals herald the opening of the foot-ball season with the record of a death.

By slowly sipping cold water it is said that many cases of headache may be cured,—Psychotherapy?

THE authorities of Queen's College, Belfast, have decided to admit female students of medicine during the ensuing session.

GEORGE P. THOMAS has been elected Resident Physician of the Jewish Hospital, in place of A. W. Rocap, resigned.—*Record.*

A CASE of smallpox has appeared in Chicago, in the person of a young man who had just come from Havre, where the disease now prevails.

In the report of the proceedings of the *Mississippi Valley Medical Association*, Dr. Francis Dowling's name was erroneously spelled with a B.

ELEMENTARY instruction in medicine shall hereafter be given in the Orthodox seminaries of the Russian Empire, by decree of the Holy Synod.

EIGHTEEN premature infants have been saved by the couveuses at the Philadelphia Woman's Hospital. No cases of failure have as yet been recorded.

WE regret to hear of the death of the senior partner of the firm of Lutz & Movius, of New York. Mr. Lutz was one of those gentlemen with whom a business interview was a pleasure.

Sir Edwin Arnold says that in India, with 200,000,000 inhabitants, a love-match never occurs; and yet there are more happy marriages, happy homes, and pure domestic relations than anywhere else in the world.

We judge that Mr. Arnold must be about 80 years old.

IN our recent report of the proceedings of the *Mississippi Valley Medical Association*, the name of the treasurer should have been Dr. C. F. McGahan, of Chattanooga, Tenn., instead of Dr. Chapman, who was former treasurer.

THE following are the selections for this season's Health Talks to Young Men in the Hall of the Young Men's Christian Association, upon the evenings of the dates assigned. Music or gymnastics will precede the lectures: Dr. Frank Woodbury, Digestion and Diet, October 8. Dr. J. P. Crozier Griffith, Respiration and Circulation, October 17. Dr. Charles K. Mills, The Brain and Its Functions, October 24. Dr. De Forest Willard, Some Emergencies and How to Meet them, October 31.

THE recent session of the International Congress of Medical Jurisprudence was successful beyond the most sanguine expectations of its promoters. It perfected a permanent organization and provided for the selection of an additional vice-president from each State and Territory of the American Union, and from each foreign province, State and country who had members in the organization that took an interest in the success of the movement.

The expenses of publishing all the papers read at this Congress, with a record of its transactions and the proceedings at the banquet, will fill a large volume, the expense of which is estimated will be about \$700. The Executive Officers were authorized to elect additional members into the organization, the only expense of which is the enrolling fee of \$3.00, which entitles the member to the *Bulletin* free.

Co-operation is earnestly solicited in all localities, and names will be laid before the Executive Officers for enrollment as members on receipt of the enrolling fee, which can be sent to any officer of the body.

The officers elected by the Congress, held June 4th to 7th, 1889, in New York, were as follows: President, Clark Bell, Esq., of New York; Secretary, Moritz Ellinger, Esq., of New York.

To Contributors and Correspondents.

ALL articles to be published under the head of original matter must be contributed to this journal alone, to insure their acceptance; each article must be accompanied by a note stating the conditions under which the author desires its insertion, and whether he wishes any reprints of the same.

Letters and communications, whether intended for publication or not, must contain the writer's name and address, not necessarily for publication, however. Letters asking for information will be answered privately or through the columns of the journal, according to their nature and the wish of the writers.

The secretaries of the various medical societies will confer a favor by sending us the dates of meetings, orders of exercises, and other matters of special interest connected therewith. Notifications, news, clippings, and marked newspaper items, relating to medical matters, personal, scientific, or public, will be thankfully received and published as space allows.

Address all communications to 1725 Arch Street.

Army, Navy & Marine Hospital Service.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, United States Army, from September 29, 1889, to October 5, 1889.

KENDALL, WILLIAM P., Assistant-Surgeon. Granted leave of absence for one month. S. O. 93, Dept. of the Platte, October 2, 1889.

TREMAINE, WILLIAM S., Surgeon. Relieved from temporary duty at Fort Leavenworth, Kansas, and will return to his home, Buffalo, N. Y. Par. 13, S. O. No. 230, A. G. O., October 3, 1889.

BILLINGS, JOHN S., Surgeon. Detailed as delegate to represent the Medical Department of the Army at the annual meeting of the American Public Health Association, to be held at Brooklyn, N. Y., October 22, 1889. Par. 10, S. O. No. 230, A. G. O., October 3, 1889.

POINDEXTER, JEFFERSON D., Assistant-Surgeon. Granted leave of absence for one month. S. O. No. 113, Headqrs. Dept. of Dakota, September 30, 1889.

POPE, BENJAMIN F., Surgeon. Relieved from duty at Fort Clark, Texas, and will report for duty to commanding officer, Whipple Barracks, Arizona Territory. Par. 11, S. O. No. 230, A. G. O., October 3, 1889.

ADAIR, GEORGE W., Captain and Assistant-Surgeon. Leave of absence for one month. S. O. 90, Headqrs. Dept. of the Platte, September 25, 1889.

POPE, BENJAMIN F., Major and Surgeon. By direction of the Secretary of War, the leave of absence granted in S. O. No. 54, August 17, 1889, Dept. of Texas, is extended one month. Par. 6, S. O. 224, A. G. O., September 26, 1889.

CHAPIN, ALONZO R., Captain and Assistant-Surgeon. With the approval of the Secretary of War, leave of absence for fourteen days is granted. Par. 10, S. O. 223, A. G. O., September 25, 1889.

BURTON, HENRY G., Captain and Assistant-Surgeon. By direction of the Secretary of War, will report in person, on the expiration of his present sick-leave of absence, to the commanding officer, David's Island, New York, for temporary duty at that station, and by letter to the superintendent, recruiting service. Par. 3, S. O. 223, A. G. O., Washington, September 25, 1889.

LORING, LEONARD Y., Major and Surgeon. Station is changed by direction of the Secretary of War, from Fort Mojave, Ariz. Ty., to Fort Wingate, N. Mex., and he will report for duty at the latter accordingly. Par. 7, S. O. 219, A. G. O., September 20, 1889.

Changes in the Medical Corps of the United States Navy for the week ending October 5, 1889.

HARMON, GEORGE E. H., Surgeon. Detached from the U. S. S. Constellation, and ordered to Naval Academy.

LOWNES, C. H. T., Assistant-Surgeon. Detached from the U. S. S. Constellation, and to Naval Academy.

WINSLOW, GEORGE F., Surgeon. Ordered to Marine Rendezvous, Boston.

HENRY, CHARLES P., Assistant-Surgeon. Ordered before the Retiring Board for examination.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service for the six weeks ended October 5, 1889.

FESSENDEN, C. S. D., Surgeon. Granted leave of absence for thirty days. October 3, 1889.

WYMAN, WALTER, Surgeon. Granted leave of absence for thirty days. September 3 and 21, 1889.

SAWTELLE, H. W., Surgeon. Granted leave of absence for seven days. September 26, 1889.

AUSTIN, H. W., Surgeon. Granted leave of absence for thirty days. September 9, 1889.

GASSAWAY, J. M., Surgeon. When relieved at New Orleans, La., to rejoin station at Cairo, Ill. September 30, 1889.

GOLDSBOROUGH, C. B., Surgeon. Leave of absence extended thirty days, on surgeon's certificate of disability. September 16, 1889.

ARMSTRONG, S. T., Passed Assistant-Surgeon. Relieved from duty at New York; ordered to command of service at Cleveland, Ohio. September 17, 1889.

AMES, R. P. M., Passed Assistant-Surgeon. Assigned to duty at New Orleans, La., upon expiration of leave of absence. September 30, 1889.

WHITE, J. H., Passed Assistant-Surgeon. Leave of absence extended thirty days, on surgeon's certificate of disability. September 21, 1889.

NORMAN, FENTON, Assistant-Surgeon. Granted leave of absence for thirty days, to take effect when relieved. October 4, 1889.

PETTUS, W. J., Assistant-Surgeon. Ordered to Portland, Me., for temporary duty. September 26, 1889. Granted leave of absence for twenty-six days, to take effect when relieved. October 6, 1889.

KENYOUN, J. J., Assistant-Surgeon. Granted leave of absence for thirty days. September 28, 1889.

Medical Index.

We purpose on this page to give a list each week of the more important and practical articles appearing in the contemporary foreign and domestic medical journals.

Accoucheur, the, and his forceps, Barnes. *The Practitioner and News*, Sept. 28, 1889.

Acute intestinal obstruction complicating strangulated hernia; herniotomy, with subsequent laparotomy recovery, Way. *Med. News*, Oct. 5, 1889.

Adénites aigues, par le Dr. Daudois. *Revue Medicale de Louvain*, Juillet, 1889.

A few clinical cases, showing the value of oxygen combined with nitrogen-monoxide, in the treatment of pulmonary and other troubles. E. C. Titus, M.D. N.Y. *New York Medical Record*, Oct. 5, 1889.

Aseptic surgery, Burrell. *The Boston Med. and Surg. Journal*, Oct. 3, 1889.

Angular curvature, nature of the physiological failures which superinduce vertebral deformity, Taylor. *New York Med. Journal*, Oct. 5, 1889.

Antipyretics in various diseases, attended with abnormal elevation of animal heat; general propositions with reference to the employment of, Jones. *Virginia Medical Monthly*, Oct., 1889.

Antiseptic treatment and protection for the membrana tympani in perforations, the result of otorrhœa, the value of, Turnbull. *Virginia Med. Monthly*, Oct. 1889.

Cæsarean section, a case of, Hays. *N. C. Med. Jour.*, Sept., 1889.

Calcul vesical. Taille hypogastrique; par le Dr. Thisguen. *Revue Medicale de Louvain*, France, Juillet, 1889.

Chlorosis, simple anaemia, and pernicious anaemia, including leucocytæmia and Hodgkin's disease, Henry. *Medical News*, Oct. 5, 1889.

Chronic diseases of the upper air-passages, on the connection of, Freudenthal. *The Journal of the Amer. Med. Ass'n*. Oct. 5, 1889.

Cocaine, as a local anaesthetic, Long. *The Peoria Medical Monthly*, Sept., 1889.

Colon, flushing of the, Etheridge. *The Peoria Medical Monthly*. Sept., 1889.

Creasote, in fifty cases of disease of the air-passages, the value of, Watson. *Virginia Med. Monthly*, Oct., 1889.

Deafness, its causes and prevention, from a rational standpoint, Hays. *N. C. Med. Journal*, Sep., 1889.

De la nephrorraphie, M. le Prof. Trélat. *La France Medicale*, Sept. 21, 1889. Paris.

De la pluralité des experts; par A. Cesné. *La Normandie Medicale*, Sept. 15, 1889. Rouen, France.

Der unregelmässige Bau des Brustkastens als Faktor in der Disposition zur Tüberkulose, Maszkowski. 23 Sept., 1889.

Des affections réflexes provenant de la muqueuse nasale, etc. Par le Dr. Palo. *Gazette Medicale de Nantes*, Sept. 9, 1889.

Des toniques du cœur, par M. Bucquoy. *La France Medicale*, Sept. 19, 1889. Paris.

Deux cas d'ostéomyélite infectieuse, ayant comme portes d'entrée: l'un une lymphangite d'origine traumatique, l'autre une bleorrhagie ancienne; par le Dr. Cauchois. *La Normandie Medicale*, Sept. 15, 1889. Rouen, France.

Die Therapie der Augenmuskellähmungen, Mauthner. *Wiener Medizinische Blätter*, 19 Sept., 1889.

Die Zukunft der Mikroskopie, Heitzmann. *Ibid.*

Digitalis, therapeutic value of, Smart. *The Toledo Medical and Surgical Reporter*, October, 1889.

Eclampsia puerperal de familia, Murillo. *Revista Médica de Chili*.

Etiology and treatment of pelvic abscess, Dunning. *Indiana Medical Journal*, Oct., 1889.

Evolution in the causation of disease, G. N. Best, M.D. Lehigh Valley Medical Magazine, Oct., 1889.

Forensic microscopy, or the microscope in its legal relations, Lewis. *The American Monthly Microscopical Journal*, Sept., 1889.

Gangrenous lipoma operation, clinical remarks on a, Nisbet. *N. C. Med. Journal*, Sept., 1889.

Gastric neurasthenia, Garland. *The Boston Medical and Surgical Journal*, Oct. 3, 1889.

Gonorrhœa, the principles that should guide us in the rational treatment of, Lewis. *American Practitioner and News*, Sept. 28, 1889.

Greffre zooplastique faite avec la peau de poulet. Cicatrisation rapide. M. Bilhaut. *Annales d'Orthopédie*, Sept. 15, 1889.

Hypertrophie de la jambe droite, Marc Sée, rapporteur. *Bulletin de l'Academie Medecine*, Sept. 17, 1889. Paris.

Idiosyncrasy to quinine, peculiar case of, Evans. *Medical News*, Oct. 5, 1889.

Influence and work of the Academy; being an address delivered at the laying of the corner stone of the New York Academy of Medicine, Oct. 2, 1889, by A. Jacobi, M.D. N.Y. *New York Medical Record*, Oct. 5, 1889.

Intussusception and the use of injections. H. E. Forest, M.D. N.Y. *New York Medical Record*, Oct. 5, 1889.

Is Senn's gas test infallible and always devoid of danger? Dalton. *Weekly Medical Review*, Sept. 28, 1889.

La Croix-Rouge française; feuilleton par le Dr. Every Body. *Journal d'Hygiène*, Sept. 12, 1889. Paris.

Laparotomy, in a case of dermoid cyst, Dary. *Med. News*, Oct. 5, 1889.

Le gaiacol, M. L. Jumon. *La France Medicale*, Sept. 12, 1889. Paris.

Le lavage de la vessie par la voie sus-pubienne comme complément de la jonction évacuatrice; par le Dr. F. Verchére. *La France Medicale*, Sept. 1889.

Le sort des tuberculeux dans l'avenir; par Henry Bennet, D.M.P. *Journal d'Hygiène*, Sept. 12, 1889. Paris.

Litholapaxy, in children, Allen. *The Journal of the Amer. Med. Ass'n*, Oct. 5, 1889.

Lymphangite chez un diabétique. *Annales d'Orthopédie*, Sept. 15, 1889.

Massage, Spink. *Indiana Med. Journal*, Oct., 1889.

Medical practice in the United States, the legal restrictions of, Millard. *The Journal of the Amer. Medical Ass'n*, Oct. 5, 1889.

Nasal differentiation, Woolen. *American Practitioner and News*, Sept. 28, 1889.

On the bacteriological test of drinking-water. Edward K. Dunnam, M.D. N.Y. *New York Med. Record*, Oct. 5, 1889.

Os'eo-myélite de l'humérus, hemorrhagies, mort; par le Dr. Bellonard. *Gazette Medicale de Nantes*, Sept. 9, 1889.

Physician and specialist, North. *The Toledo Medical and Surgical Reporter*, Oct., 1889.

Rectal cystotomy, Bauer. *American Practitioner and News*, Sept. 28, 1889.

Rein kystique, cancer ano-rectal. Prof. Trélat. *La France Medicale*, Sept. 17, 1889.

Remarques sur l'hérédité; par le Dr. Hervonet. *Gazette Medicale de Nantes*, Sept. 9, 1889.

Sur l'action physiologique et thérapeutique de la methylacétanilide (exalgine); par le Dr. Gaudineau. *Bulletin Général de Thérapeutique*, Sept. 15, 1889. Paris.

Sur une tumeur de la parotide, M. Campenon. *La France Medicale*, Sept. 10, 1889. Paris.

Railway shock and its treatment, F. X. Dercum, M.D. *Lehigh Valley Medical Magazine*. Oct. 1889.

Traitemen de l'hydrocile avec ou sans épaisseissement de la tunique vaginal; par le Prof. Verneuil. *Annales d'Orthopédie*, Sept. 15, 1889.

Traitemen de l'incontinence nocturne d'urine chez les enfants; par le Dr. Auguste Ollivier. *Bulletin Général de Thérapeutique*, Sept. 15, 1889. Paris.

Trepanation du crâne en dehors du traumatisme; par M. Ueber die Prophylaxis durch Nahrung, Dujardin-Beaumetz. *Wiener Medizinische Blätter*, 19 Sept., 1889.

Lucas-Championniere. *Annales d'Orthopédie*, Sept. 15, 1889.

Vaccine ulcereuse, par M. Hervieux. *Bulletin de l'Academie Medecine*, Sept. 17, 1889. Paris.

Vomissements de la grossesse, par M. Gueniot. *Bulletin de l'Academie Medecine*, Sept. 17, 1889. Paris.

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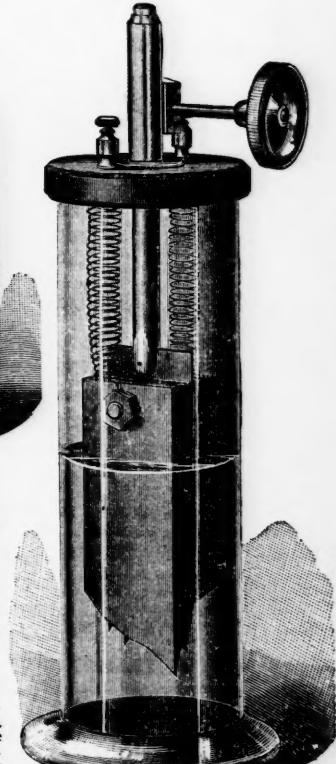


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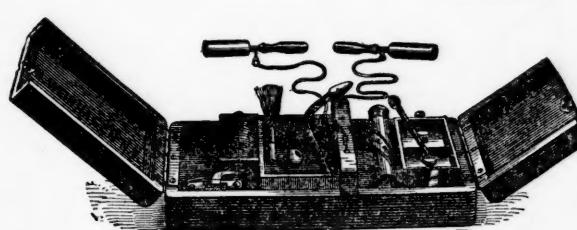
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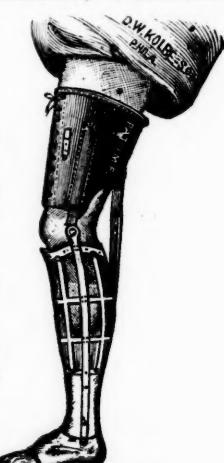
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UNRIValed AS A UTERINE TONIC IN IRREGULAR, PAINFUL, SUPPRESSED AND EXCESSIVE MENSTRUATION.

It Restores Normal Action to the Uterus, and Imparts Vigor to the Entire Uterine System.

Where women have miscarried during previous pregnancies, or in any case where miscarriage is feared, the ALETRIS CORDIAL is indicated, and should be continuously administered during entire gestation.

CHAR. CLAY, M. R. C. S., Manor House, Dewsbury, England, says:—I find Aletris Cordial (Rio) is of great service in threatened miscarriage.

FRANCIS E. CANE, L. R. C. S., &c., Leeds, England, says:—I have tried the Aletris Cordial (Rio) in two cases of long standing dysmenorrhea, with excellent results. One of these patients has spent a week in bed every month for two years. After all the usual remedies, I put her on Aletris Cordial, and for the last two periods she has been out and about all the time.

L. M. WATSON, M. D., Delhi, Ills., says:—I have used Aletris Cordial (Rio) in cases of dysmenorrhea, suppressed menses, and threatened miscarriage, and also, combined with Celerina, as a tonic after confinement, with the happiest results, and now I am using it on a case of leucorrhœa, with injections of S. H. Kennedy's Extract of Pinus Canadensis, and it is acting like a charm.

P. H. OWEN, M. D., Morganville, Ala., says:—I have prescribed Aletris Cordial (Rio) in several cases with the most satisfactory results, and regard it as the best uterine tonic I have met with in a professional experience of over twenty-five years. In cases of threatened miscarriage it acts like a charm. Would recommend its continuous administration in all cases when there is any indication of miscarriage.

DR. W. BERTHELOT, Santander, Spain, says:—I have tried the Aletris Cordial (Rio), and it has seemed to me to be useful, especially in cases of dysmenorrhea.

DR. RASQUINER, Jupille, near Liege, Belgium, says:—I tried Aletris Cordial (Rio) in the case of a woman who had had several miscarriages at the end of five months, and who is now again pregnant, having reached the seventh month: thanks to Aletris Cordial.

R. REECE, M. R. C. S., Walton-on-Thames, England, says:—Aletris Cordial (Rio) in painful menstruation is most valuable. A wife of a minister suffered much, and had had three miscarriages. I prescribed Aletris Cordial. She has for the first time, gone her full time, and was safely confined with a male child.

J. T. COLLIER, M. D., Brooks, Me., says:—I have used your Aletris Cordial (Rio) in cases of females at the menopause. Consider it one of the finest remedies for these cases.

DR. GORDILLON, St. Amand, France, says: I have tried the Aletris Cordial (Rio) in a case of dysmenorrhea. The result I obtained from the use of your preparation was excellent, better than I had obtained in the same patient by prescribing the usual remedies employed in such cases.

W. F. TOOMBS, M. D., Morrillton, Ark., says:—I have used a great deal of your Aletris Cordial (Rio) and I find it all you claim for it in amenorrhea, dysmenorrhea, metritis, leucorrhœa; I don't think it has an equal. I have used it in two cases of threatened miscarriage and the trouble was obviated. For a general Uterine Tonic I know of nothing superior.

R. D. PATTERSON, L. R. C. S. &c., Medical Officer, Caledon Dispensary, Co. Tyrone, Ireland, says:—I have very great pleasure in testifying to the very high opinion I hold of Aletris Cordial (Rio) in threatened miscarriage.

RIO CHEMICAL CO., ST. LOUIS, MO., U. S. A.

LONDON,
16 Coleman St.

CALCUTTA,
9 & 10 Dalhousie Square.

PARIS,
5 Rue de la Paix.
MONTREAL,
874 St. Paul St.

Pepsin in Infantile Diarrhœa.

In a recent number of a Journal appears an advertisement under the above caption, which goes on to show that "one of the causes which incites and perpetuates the gastric and intestinal inflammation is undigested, or partially digested, fermenting milk or other food," and that "it is as an aid to the removal of this cause, both in predigesting milk or other food before it is given, and in digesting fermented undigested food in the stomach, that pepsin is indicated in infantile diarrhoea, and its efficacy has been well attested by many well known medical writers," all of which is undoubtedly true.

But the active principles of commercial pepsins are the pepsin ferment proper, and the milk-curdling ferment, and it being only the latter that is concerned in the diet of nursing infants, just to the extent a pepsin contains the curdling ferment is it useful in infantile diarrhoea. Hence, all that the advertising company referred to has to say about the wonderful digestive power of its pepsin as applied to *albumen*, is something like trying to prove black to be white by stating that something else is white—in other words, assuming the statement of the company to be true as regards the digestive power of its pepsin (and it is an assumption), such a mode of test is no proof whatever of the value of the article in infantile diarrhoea.

That the pepsin referred to possesses the *very odor* that its manufacturer names as characteristic of putrefaction, is not only a self-condemnatory fact, but is a sign of danger inadvertently hung out by this would be authority.

All soluble forms of what are termed pure pepsin (*i. e.* free from added material) are more or less hygroscopic, and the pepsin referred to is no exception in this particular—though the company manufacturing it claim the contrary. Any one can prove this by exposing to the air, side by side during damp weather, samples of soluble pepsins, using for control a sample of Ford's Pepsin which will be found unaffected by prolonged contact with moist air. Air, heat and moisture are the essential conditions of putrefaction. Either of the two former cannot be guarded against in the case of pepsin, nor is it necessary that they should if ordinary care is exercised against unnecessary exposure. When a manufacturer advises the use of a hygroscopic pepsin as though it were non-hygroscopic, there is liable to be rapid deterioration if the user obeys instructions, and consequently but little medicinal advantage derived, no matter how high the test of the article when fresh.

The medical profession has so long and successfully used

GOLDEN SCALE PEPSIN

for liquid forms and combinations, and

FORD'S PEPSIN

for all dry forms where exposure has been necessary, and either or both for predigestion of foods as well that they may well be ranked as

THE STANDARD PEPSINS.

These have stood the test of time, and withstood the attacks of competitors, therefore must possess intrinsic merits which is the best endorsement.

New York & Chicago Chemical Co.,

96 MAIDEN LANE, NEW YORK.

In corresponding please mention The Times and Register.



PREPARED FOR THE USE OF
NEW YORK PHYSICIANS
IN 1844.



TARRANT'S Effervescent Seltzer Aperient

AN EFFICACIOUS AND PALATABLE APERIENT

SPECIALLY INDICATED IN

Diseases of the Stomach, Liver and Spleen, in Dyspepsia accompanied
by Acidity, Irritation of the Stomach, Heartburn, Sick Headache.

A VALUABLE SALINE FOR PATIENTS OF

RHEUMATIC OR GOUTY DIATHESIS.

PARTICULARLY ADAPTED FOR USE IN THE

CONSTIPATION OF PREGNANCY.

In addition to its aperient and antacid qualities, it proves to be
an ADMIRABLE VEHICLE FOR THE ADMINISTRATION OF
TINCTURE OF IRON, SALICYLIC ACID, THE SALICYLATES,
CITRATE OR CARBONATE OF LITHIA, ETC.

When used as a vehicle, it is only necessary to add the
medicine to be administered (preferably in solution) to half a
goblet of water, stir in half a teaspoonful of Aperient, and drink
during effervescence. Administered in this way, Physicians
will find unpleasant remedies not only taken without nausea,
but introduced into the stomach in a condition to be assimilated
more readily.

The favorable results obtained from the use of this Aperi-
ent, and the readiness with which it is taken by patients of all
ages, have obtained for it the most favorable notice of the pro-
fession during the last forty years.



MANUFACTURED ONLY BY
TARRANT & CO.

Manufacturing Pharmacists,

ESTABLISHED 1834.

NEW YORK.



Editor Medical Brief, St. Louis, Mo.:

The family doctor alone knows how widespread Melancholia is in our country. The many household cares develop this disease in nervous women, who show its first symptoms in fretfulness and worry. I have sought for a remedy for years for this malady and have at last found it in the triple valerianates, which worked like a charm:

Zinci Valerianat -	-	-	-	-	-	20 grs.
Quiniæ Valerianat -	-	-	-	-	-	20 grs.
Ferri Valerianat -	-	-	-	-	-	20 grs.

(M. ft. pl. No. 20. Sig.: One, three times a day.)

The drugs must be absolutely pure. The old reliable house of W. H. Schieffelin & Co., of New York, have added the above pills (soluble) to their list, and I have tried them in many cases and I find them a specific for the worry of nervous women, melancholia and incipient insanity.

Please try them and report. Your success will be sure.

S. A. DE FOE, M.D., Washington, N. J.

PIL. QUINIÆ FERRI ET ZINCI VALERIANAT, W. H. S. & CO.

Quiniæ Valerianat -	-	-	-	-	-	1 gr.
Ferri Valerianat -	-	-	-	-	-	1 gr.
Zinci Valerianat -	-	-	-	-	-	1 gr.

Highly recommended for melancholia, and the fretfulness and worry of nervous women.

When this pill was first introduced by us, the interest of the Medical Profession throughout our country was aroused to such an extent as to create a demand which for a time we found it difficult to supply. That demand has continued, thus indicating the popularity and efficiency of this formula.

Timely remedies in pill form prepared by W. H. Schieffelin & Co.,

ANTIPYRETTICS.

Pil. Phenacetine, "W. H. S. & Co." 2, 4 and 5 grs.

Pil. Acetanilid, "W. H. S. & Co., 1, 2 and 5 grs.

Pil. Warburg's Tincture, with or without Aloes, "W. H. S. & Co."

ANALGESICS.

Pil. Phenacetine, "W. H. S. & Co.," 2, 4 and 5 grs.

Pil. Codeia, "W. H. S. & Co.," 1-16, 1-8, 1-4 and 1-2. grs

Pil. Sulfonal—Bayer, "W. H. S. & Co.," 5 grains.

Pil. Hyoscyami, "W. H. S. & Co.," 1-300, 1-200, 1-100 and 1-50 gr.

INTESTINAL ANTISEPTIC.

Pil. Salol, "W. H. S. & Co.," 2 1-2 and 5 grs.

For full information regarding our Soluble Pills we would refer to our Formula Book, which will be furnished on application.

W. H. Schieffelin & Co.,

170 & 172 WILLIAM STREET, NEW YORK.

Please mention The Times and Register.

Carlsbad Natural Mineral Waters,

FAC-SIMILE OF BOTTLE.
(Two-thirds of actual size.)



"SPRUDEL," "SCHLOSSBRUNN," "MUHLBRUNN,"

Obtained from the celebrated Alkaline and Saline Springs of CARLSBAD, Bohemia.

These Waters are imported in bottles and may be used in the treatment of Chronic Gastric Catarrh, Hyperemia of the Liver, Gallstones, Chronic Constipation, Diabetes, Renal Calculi, Gout, and diseases of the spleen arising from residence in the tropics or malarious districts.

THE NATURAL CARLSBAD MINERAL WATERS are unsurpassed for the cure of Catarrh of the Stomach, and diseases of the Liver, Kidneys and Bladder, Diabetes, Rheumatism, Gout, Chronic Constipation, and Obesity. To increase the aperient action of the Natural Carlsbad Mineral Waters, a teaspoonful of the imported Carlsbad Sprudel Salt, previously dissolved in a little hot water, should be added.

Dr. B. London says: "The Natural Mineral Waters of Carlsbad Accelerate Absorption, Stimulate Nutrition, Correct Acidity, Aid Digestion, Calm the Nerves. Soothe Irritation and Purify the Blood. In my experience they have proved the Most Reliable Curative Agent I ever employed."

THE GENUINE IMPORTED

Natural Carlsbad Sprudel Salt,

In Powder Form, is Evaporated from the Sprudel Spring. It is Highly Recommended as an

APERIENT, LAXATIVE, AND DIURETIC,

Easily Soluble, Palatable, and Permanent. As an Aperient it should be given before breakfast
Pamphlets mailed upon application.

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SUCCUS ALTERANS. (McDADE.)

SUCCUS ALTERANS is a purely vegetable compound of the preserved juices of *Stillingia Sylvatica*, *Lappa Minor*, *Phytolacca Decandra*, *Smilax Sarsaparilla*, and *Xanthoxylum Carolinianum*, as collected by DR. GEO. W. McDADE exclusively for ELI LILLY & CO., and endorsed by DR. J. MARION SIMS.

SUCCUS ALTERANS continues to gain favor from its remarkable Alterative and Tonic properties, *eliminating specific poison from the blood and increasing the proportion of red corpuscles in anæmic patients* to a wonderful degree; is endorsed by the medical profession and in use by many hospitals of note.

SUCCUS ALTERANS in venereal and cutaneous diseases is fast supplanting Mercury, the Iodides and Arsenic; and is a certain remedy for Mercurialization, Iodism, and the dreadful effects often following the use of Arsenic in skin diseases.

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SUCCUS ALTERANS is giving satisfactory results in treatment of *Chronic Rheumatism* and can be used with confidence.

SUCCUS ALTERANS may be given for any length of time without injury to the patient.

SUCCUS ALTERANS is put up in pint round amber bottles and *never in bulk*.

PHYSICIANS who have not received DR. McDADE's latest publication, the *MONOGRAPHIA SYPHILITICA*, should send their address, mentioning this Journal, and we will mail a copy. It contains a paper, illustrated with colored plates, by DR. D. H. GOODWILLIE, of New York, on the "Sequelæ of Syphilis," reports of cases in practice, and many other valuable papers.

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"THE QUEEN OF TABLE WATERS."

The filling at the Apollinaris Spring [Rhenish Prussia], during the year 1887 amounted to

11,894,000 Bottles,

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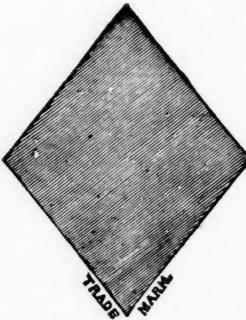
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THE APOLLINARIS COMPANY, Limited, London, beg to announce that, as numerous Aperient Waters are offered to the public under names of which the word "Hunyadi" forms part, they have now adopted an additional Label comprising their registered Trade Mark of selection, which consists of

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DEMAND THE DIAMOND MARK.



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